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Lord Charles Falconer, Chair *www.commissiononassisteddying.com*

# THE EFFECTIVENESS OF LEGAL SAFEGUARDS IN JURISDICTIONS THAT ALLOW ASSISTED DYING

Penney Lewis and Isra Black

January 2012

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## EXECUTIVE SUMMARY

Evidence from jurisdictions that allow assisted dying is frequently used in the debate about assisted dying in the UK, since it provides important information about how assisted suicide and voluntary euthanasia work in practice. However, in order to interpret these data meaningfully, it is essential that they are understood in the context of the different legal and regulatory frameworks in operation in these countries.

The Commission on Assisted Dying has commissioned this expert briefing paper in order to help unpick these complexities, and identify evidence for the effectiveness of the various legal safeguards that have been employed in jurisdictions that allow assisted dying.

In the briefing paper the authors identify and explain the features of the legal regimes that regulate assisted dying in four target jurisdictions: the Netherlands, Belgium, Oregon and Switzerland. They explore the evidence for the effectiveness of individual safeguards in each of these regimes in turn. Then they evaluate the evidence for the effectiveness of each safeguard, drawing on a detailed examination of the evidence, and, where possible, make recommendations on how these regimes could implement and regulate assisted dying more effectively.

### Features of assisted dying regimes

The briefing paper identifies eight categories of safeguard that are used in jurisdictions that permit assisted dying and specifies how each of these safeguards is applied in the Netherlands, Belgium, Oregon and Switzerland. These categories are: the type of assistance; the person's condition and/or experience of suffering; making the request for assistance; the age of the person requesting assistance; consultation and referral requirements; the identity of the assistor; due medical care; and the reporting and scrutiny of cases.

#### Type of assistance

In the Netherlands, both euthanasia (understood as termination of life on request) and assisted suicide are legally permitted, if performed by physicians in accordance with the statutory due care

criteria set out in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001.

In Belgium, the Euthanasia Act 2002 allows only physicians to perform euthanasia (also understood as termination of life on request). Assisted suicide is not explicitly covered, although Belgium's oversight body, the Federal Control and Evaluation Commission, has accepted that cases of assisted suicide fall under the law.

In Oregon, the first Death with Dignity Act was passed in 1994. The act permits physician assisted suicide in one form: the provision of a prescription for lethal medication, to be self-administered by the patient. Neither euthanasia, nor any other form of physician assisted suicide is permitted.

In Switzerland it is only a criminal offence for a person to assist another person's suicide if the assistor has a selfish motive. Almost all assisted suicides take place within frameworks set up by individual not-for-profit right to die organisations such as Dignitas, Exit ADMD and Exit Deutsche Schweiz (EDS). Euthanasia is not permitted in Switzerland, although the offence of homicide at the request of the victim carries a lower sentence than murder.

### Condition and/or experience of suffering

The legal requirements relating to the requesting person's condition and/or experience of suffering vary widely across these jurisdictions.

In the Netherlands, 'the attending physician… must have been satisfied that the patient's suffering was unbearable, and that there was no prospect of improvement'.[1] The patient's suffering need not be related to terminal illness, and it is not limited to physical suffering such as pain. A related due care criterion is that there must be 'no reasonable alternative in light of the patient's situation'.[2]

In Belgium, the 'patient [must be] in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident'.[3] Like the Netherlands, there is no requirement that the patient has a terminal illness. Additional

procedural requirements are imposed if the patient is 'clearly not expected to die in the near future'.[4]

In Oregon, the patient must be suffering from a terminal disease, defined as 'an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgement, produce death within six months'.[5] There is no additional requirement relating to the patient's experience of the disease or any minimum level of suffering.

In Switzerland, selfless suicide assistance is in principle legal irrespective of the condition of the individual who dies. However, the supply of barbiturates is subject to federal narcotics law, which permits physicians to dispense lethal medication only within the limits of accepted professional practice. The Swiss Academy of Medical Sciences (SAMS) has outlined what constitutes accepted practice in its medical ethical guidance. The Swiss physician must examine the individual seeking assistance and previously, 'a condition indisputably leading to death' was held to be a requirement of accepted practice.[6] However, in 2006 the Federal Supreme Court held that in some circumstances the suffering caused by a mental disorder could cause a person 'to suffer to the extent that he no longer regarded his life worth living'.[7]

### Making the request for assistance

In the Netherlands, the patient's request must be 'voluntary and carefully considered'.[8] The patient must be competent to make such a request and the attending physician must consult a psychiatrist if he or she suspects the patient is incompetent. The request must also be well informed. The statute does not require the request to be in writing. The statute does allow termination of life on *advance request*, if a competent person becomes incompetent after having made a written declaration of his request.

In Belgium, the patient must be 'legally competent' and the request must be 'completely voluntary' and 'not the result of any external pressure'. The physician must inform the patient about 'his health condition and life expectancy' and 'the possible therapeutic and palliative courses of action and their consequence'.[9] The patient's request must be in writing and a request may be made in advance. However, since the triggering condition is unconsciousness,

advance requests will not be applicable to many scenarios of future incompetence including dementia.

In Oregon, the competence, voluntariness and information requirements are set out in some detail. The request must be in writing and two witnesses must attest that the patient is acting voluntarily and is not being coerced. The patient must make an 'informed decision… that is based on an appreciation of the relevant facts' (which are described in detail in the act).[10]

In Switzerland, the person assisted with suicide must have capacity if their act is to be considered suicide. The physician must personally examine the person seeking assistance and assess their capacity according to the test set out in the Civil Code. Individual right to die associations have also developed their own tests.

### Age of person requesting assistance

In Dutch law a patient between the ages of 16 and 18 who is 'capable of making a reasonable appraisal of his own interests'[11] may request euthanasia or assisted suicide. The parent or guardian must be consulted but does not have a veto. Patients between 12 and 16 must also pass the same capacity test, and in addition the parent or guardian's consent is required.

In Belgium, euthanasia is legal only for patients over the age of 18 and for minors over 15 who have been 'legally emancipated'. The Oregon law applies only to patients over the age of 18. In Switzerland, children cannot have the required legal capacity to commit suicide, though the position for adolescents is unclear.

### Consultation and referral requirements

In the Netherlands, an independent physician must see the patient and give a written opinion on whether the due care criteria are met. The consultation requirements are more stringent if the patient's suffering is the result of a psychiatric disorder. Most reported euthanasia cases involve a consultant from the state-funded programme Support and Consultation on Euthanasia in the Netherlands (SCEN).

In Belgium, the consulting physician must examine the patient and the medical record and ensure that the suffering requirement has been met. If the patient 'is clearly not expected to die in the near

future', there is a mandatory additional consultation with either a psychiatrist or relevant specialist, and a waiting period of at least one month.[12] The Life End Information Forum (LEIF) service, which is similar to the SCEN programme, has been developed in Flanders to provide advice to doctors. A consultation with a palliative care expert is not legally required, but many Catholic hospitals in Flanders impose such a palliative filter in addition to the statutory criteria. The law requires the patient's request for euthanasia to be discussed with the nursing team involved in caring for the patient.

In Oregon, the attending physician must refer the individual requesting assisted suicide to a physician who is qualified to make a professional diagnosis and prognosis of the patient's disease. The physician must also determine that the patient is capable and acting voluntarily. A counselling referral must be made if the attending or consulting physician suspects the patient may have a mental disorder or depression impairing their judgement, and the request may proceed only if the counsellor determines that such a condition does not exist. There is no requirement in the act that individuals experience palliative care before receiving a prescription.

The Swiss right to die organisations each follow an internal protocol to determine whether an individual meets the organisation's criteria for suicide assistance. Contact must also be made with a physician to verify independently whether the patient meets the criteria for assisted suicide. Since 2008, physicians in Zurich have been required to meet the individual seeking assistance on two occasions before a prescription is issued.

### The identity of the assistor

In the Netherlands, only physicians may lawfully provide euthanasia. The courts originally required that the person providing euthanasia was the patient's treating physician. However, the current requirement is that the physician must know the patient sufficiently well to assess whether the due care criteria are met.

The Belgian act requires that the physician has 'several conversations with the patient spread out over a reasonable period of time' to be certain of the persistence of the patient's suffering and the enduring character of his or her request. The legislative history

makes clear that the patient should be able to bypass his or her attending physician if so desired.

In Oregon, the attending physician is defined as 'the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease'.

In Switzerland, there is no legal criterion that relates to the identity of the assistor: in the absence of selfish motives, any individual may in principle assist in the suicide of another.

### Due medical care

In the Netherlands, one of the due care criteria requires the physician to have terminated the patient's life or assisted suicide with due medical care and attention. The Royal Dutch Pharmacological Association provides a list of appropriate medications. The criterion of due medical care and attention also normally requires the physician's continuous presence during the euthanasia or assisted suicide in case further medical intervention is required. This requirement also ensures that the medication to be used remains under the control of the physician.

The Belgian law does not include a provision requiring that a physician exercise due medical care when carrying out euthanasia, since all medical procedures must be carried out with due care. The Commission Féderale de Contrôle et Évaluation (CFCE) has been reluctant to develop rules on the physical presence of the physician in euthanasia cases or the medication that must be used.

The Oregon act permits only the provision of a prescription for lethal medication to be self-administered by the patient. No due care criterion is included although the physician must fulfil certain medical record documentation requirements.

In Switzerland, any form of suicide assistance is permissible in principle. However, in practice almost all cases involve a prescription of the barbiturate sodium pentobarbital. Physicians prescribing lethal medication must act in accordance with accepted medical practice.

### The reporting and scrutiny of cases

In the Netherlands for a physician to be protected by the legal defence provided by the 2001 act, he or she must report the case to

the municipal pathologist, who then passes the file to the relevant regional review committee. If this committee finds that the physician did not act in accordance with the due care criteria, the case is referred to the Public Prosecution Service.

In Belgium, compliance with the Euthanasia Act 2002 is monitored by the CFCE, to which all cases of euthanasia must be reported.

In Oregon, the physician must report each prescription written under the act to the Oregon Department of Human Services (ODHS), and report each death that results from the ingestion of the prescribed medication.

In Switzerland, assisted suicides must be reported to the local authorities as unnatural deaths. The police investigate all cases. There is no national body to which assisted suicides must be reported and no national reporting data are available.

### Making the request for assistance

#### Mental capacity

In the Netherlands and Belgium, the capacity criterion is used by physicians to weed out a significant proportion of requests. The reviewing bodies of both jurisdictions determined that the capacity criterion was met in all recent reported cases. In Switzerland prosecutions have occurred in cases where there were doubts over an individual's capacity. However, all of these prosecutions have involved mentally disordered individuals. As a safeguard, the capacity criterion appears to be effective in ensuring that incompetent individuals do not receive assisted dying. Considerable disagreement exists over the prevalence of mental disorder in individuals who request physician assisted suicide, and the influence that mental disorder may have on capacity to request assisted dying. However, in the Netherlands and Oregon, depression is significantly less prevalent in granted requests than in requests generally. The evidence would appear to suggest that individuals with depression who receive assisted dying nevertheless retain capacity to make a request.

#### Voluntariness

The voluntariness criterion is used by physicians in the Netherlands and Belgium to weed out a small proportion of requests. Recent reported cases in both of these jurisdictions all met the voluntariness criterion when examined by the relevant reviewing body. In Oregon some cases have raised voluntariness concerns due to failures to meet the witnessing requirements designed to ensure voluntariness. However, it is not known whether non-compliance with the witnessing requirements is indicative of a lack of voluntariness. It may be the case that discussions between the patient and more than one physician (as required in the Netherlands, Belgium and Oregon) are more effective at screening out voluntariness problems than simply requiring multiple witnesses to a written request.

#### Information provision

There is little evidence on the effectiveness of this safeguard. However, one small Belgian study found that the requirement was met in 100 per cent of euthanasia cases.

#### Written request

This requirement appears to be well observed where it exists. The Dutch experience indicates that in rare cases it may be difficult to fulfil, therefore there may be grounds for narrow, principled exceptions to the general rule. This requirement has particular instrumental value as an aid to retrospective scrutiny of reported cases.

#### Age of person requesting assistance

Restrictions on the basis of age appear to be well observed in all of the jurisdictions studied although the evidence base is limited. A more principled approach could be to base decisions on capacity rather than age.

### Consultation and referral requirements

#### Consultation with another physician

In the Netherlands, Belgium and Oregon, the legal consultation requirements are met in virtually all reported cases. The rate is much lower in unreported cases in Belgium and the Netherlands. No data on unreported cases exist for Oregon.

The authors recommend the adoption of a requirement for independent consultation. Such a requirement appears effective at screening out a significant proportion of cases that do not meet the substantive criteria. No data exist regarding the proportion of cases in Oregon that are screened out by consultants, but the lack of an independence requirement might suggest that the proportion is lower. Independence of the consultant is required and almost always present in the Netherlands and Belgium and the role of specially trained consultants via the SCEN and LEIF networks appears to have been welcomed by attending physicians.

#### Discussion with the nursing team

Belgium is the only jurisdiction with this consultation requirement, and the requirement is not well adhered to. There is no evidence on whether such discussion assists in screening out those who do not meet the substantive criteria.

#### Counselling referrals

Oregon is the only jurisdiction that requires counselling if an accompanying mental illness or disorder that impairs judgement is suspected. There is little data on the observation of this consultation requirement. However, there is a downward trend in the number of counselling referrals in those who do ultimately receive physician assisted suicide. There are also limited data suggesting that counselling referrals may not be taking place as often as the statute requires. To be effective, such a requirement might need to be coupled with the routine use of validated screening tools by attending physicians.

#### The use of palliative care 'filters'

The absence of a legal requirement of a palliative care filter in any jurisdiction makes it difficult to evaluate its effectiveness. However, in Belgium where institutions have imposed this additional criterion, there is evidence of consultations with palliative care teams in the reported cases.

### The identity of the assistor

#### Involvement of nurses

There is no evidence of nurses' involvement in Oregon and Switzerland, where the provision of a prescription is the only assistance provided. In the Netherlands and Belgium, nurses are

involved in administering euthanatica, but this is more likely in unreported cases (at least in Belgium) and unreported cases are most likely not labelled as euthanasia by the attending physician. One Dutch study recommended that institutional guidelines are needed to prevent the involvement of nurses in administering euthanatica, which does not conform to nurses' legal and professional duties. Studies of nurses' involvement in Belgium have made similar recommendations in favour of guidelines. Better training of nurses and doctors in their responsibilities in the context of end-of-life decision-making might help prevent unlawful behaviour. However, the most significant contribution may be to address the issues with labelling (see 'The reporting and scrutiny of cases', below).

### Relationship with the patient and conscientious objection

There are no formal requirements in any jurisdiction for a physician–patient relationship of particular length or quality. The limited data do not show whether patients who had only a brief relationship with their physician obtained assisted dying despite not meeting one or more criteria.

One might hypothesise that the more substantial the relationship between physician and patient, the easier it is for the physician to assess whether the substantive requirements are met, and the more likely that assessment is to stand up to prospective scrutiny (by a consultant) and retrospective scrutiny. However, in the presence of conscientious objection, the patient may not be able to establish a sufficiently substantial relationship with a new physician, particularly in cases involving terminal illness. No robust comparative data exist to support this hypothesis.

### Due medical care

The due medical care requirement in the Netherlands is generally well adhered to in reported cases with the small number of problems subject to scrutiny by the regional review committees.

In Oregon, complications such as regurgitation and regaining consciousness raise the question whether oral ingestion is the best means for individuals to bring about the end of their lives. It may be that other means of administration are less likely to result in complications, while also leaving no doubt about the voluntariness

of the act. Other lethal medications may also be better adapted to bringing about a rapid and peaceful death than those currently used.

The Swiss experience suggests that the use of parenteral means of administration may prevent some of the problems that have occurred in Oregon. The use of parenteral means may also obviate the need for euthanasia in the event that an individual 'lingers on'.

### The reporting and scrutiny of cases

There are no data on the reporting rate in Oregon. The reporting rates within the right to die organisations in Switzerland may be 100 per cent. In the Netherlands and Belgium, the reporting rate is rising and is significantly higher in the Netherlands (80 per cent) than in Belgium (53 per cent), where legalisation occurred more recently.

The primary reason for non-reporting in the Netherlands and Belgium appears to be a difference in labelling between physicians and researchers. Well over 90 per cent of cases labelled as euthanasia by physicians in both jurisdictions are reported. This suggests that the most important factor in raising the reporting rate is the education of physicians in the identification and correct labelling of cases that meet the definition of euthanasia, and when to report.

The regimes in the Netherlands, Belgium and Oregon all require the referral of cases that do not meet the statutory criteria to either the prosecutorial authorities, or the professional disciplinary authorities, or both. In the Netherlands, between 1999 and 2009, 0.21 per cent of reported cases were referred to the prosecutorial authorities by the regional review committees, but no prosecutions have been brought. In Belgium, no cases have been reported to the prosecutorial authorities by the CFCE. This may be because the request and consultation requirements have been met in all cases, or because Belgian doctors do not report cases that do not meet all of the legal requirements, but there is no evidence that the CFCE is not referring cases that should be referred.

In Oregon, data on the number of physicians referred to the Oregon Board of Medical Examiners for non-compliance with the DWDA

suggest that the ODHS operates a robust policy of referral in cases of non-compliance. In consideration of the principally clerical nature of non-compliance with the DWDA, it is perhaps unsurprising that the Board of Medical Examiners has not, to the authors' knowledge, to date sanctioned a single physician.

Overall, low referral rates are to be expected, either because of high rates of adherence to the rules (as in the Netherlands) or (in other jurisdictions) because non-reporting is likely in cases that do not meet the statutory criteria. Nonetheless, to foster compliance with the regulatory regime, it is essential that bodies charged with referral do in fact exercise this power in appropriate cases.

## INTRODUCTION

This briefing paper is divided into three parts. In the first part, the features of the legal regimes that regulate assisted dying in the Netherlands, Belgium, Switzerland and Oregon are identified and explained. The second part explores the evidence for the effectiveness of individual safeguards in each of these regimes in turn. In the final part, we evaluate the evidence for the effectiveness of each safeguard, drawing on a detailed examination of the evidence in part 2.

## PART 1 FEATURES OF ASSISTED DYING REGIMES

### Type of assistance

In the Netherlands, both euthanasia (understood as termination of life on request) and assisted suicide are permitted, provided that they are performed by physicians in accordance with the statutory due care criteria set out in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001.

The history of the legal change in the Netherlands remains significant, however, since the assistance that may lawfully be provided is not limited to that which is authorised by the 2001 act. Euthanasia and assisted suicide were effectively legalised through the use of the defence of necessity in prosecutions of (primarily) physicians. The defence was held by the courts to be available when physicians faced a conflict between their duties to preserve life and relieve suffering. Over some 30 years, the courts developed this duty-based defence of necessity in euthanasia cases, placing conditions on the defence, including: an express and earnest request; unbearable and hopeless suffering; consultation; careful termination of life; record keeping; and reporting. These conditions became known as *requirements of due care* or *careful practice*. The Dutch legislature eventually codified the parameters of the defence in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001. The original judicially developed necessity defence is still applied to cases involving the termination of life without request of incompetent persons, particularly neonates.

Thus in some circumstances termination of life without request is also legally justified in the Netherlands. (When prosecutions occur in such cases they are for the more serious offence of murder rather than for termination of life on request.[13]) Judicially initiated requirements of good practice have been developed for neonates and a national reporting scheme has recently been established for neonatal cases.

In Belgium, the Euthanasia Act 2002 allows only physicians to perform euthanasia (understood in the Netherlands as termination of life on request). Assisted suicide is not explicitly covered, although Belgium's oversight body, the Federal Control and Evaluation Commission (Commission Féderale de Contrôle et Évaluation or CFCE), has accepted that cases of assisted suicide fall under the law.[14] Since no prosecutions of physicians for termination of life with or without request have taken place in recent decades, it is unclear whether the defence of necessity could successfully be used by a physician who terminated a patient's life without a request, for example, in the case of a neonate.[15]

The Law on Euthanasia and Assisted Suicide came into force in Luxembourg in 2009. It is closely based on the Belgian law, although it does specifically permit physician assisted suicide as well as euthanasia (termination of life on request).

In 1994, Oregon voters passed the first Death with Dignity Act (DWDA). The act permits only physician assisted suicide in one specific form: the provision of a prescription for lethal medication to be self-administered by the patient. Washington voters passed an almost identical act in 2008. Neither euthanasia (termination of life on request) nor any other form of physician assisted suicide is permissible in Oregon or Washington. Assisted suicide outside of the Death with Dignity Act remains a criminal offence, and other active termination of life may be prosecuted as murder.

In Switzerland, it is only a criminal offence to assist the suicide of another where the assistor has a selfish motive. Almost all assisted suicides take place within frameworks set up by individual not for profit right to die organisations such as Dignitas, Exit Association pour le Droit de Mourir dans la Dignité (ADMD) and Exit Deutsche

Schweiz (EDS).[16] Euthanasia is not permitted in Switzerland,[17] although like many other European jurisdictions, the separate offence of homicide at the victim's request carries a lower sentence than murder.

### Condition and/or experience of suffering

The legal requirements relating to the requesting person's condition and/or experience of suffering vary widely across these jurisdictions. It is notable that despite this variation, over 80 per cent of all reported cases of euthanasia or physician assisted suicide in the Netherlands,[18] Belgium[19] and Oregon[20] involve cancer patients. (The data are less comprehensive for Switzerland, but it is clear that the rate of cancer patients is significantly lower than 80 per cent.[21])

In the Netherlands, the 'attending physician… must have been satisfied that the patient's suffering was unbearable, and that there was no prospect of improvement'. The patient's suffering need not be related to a terminal illness and is not limited to physical suffering such as pain. It can include, for example, the prospect of loss of personal dignity or increasing personal deterioration, or the fear of suffocation.[22] A related due care criterion is that there must be 'no reasonable alternative in light of the patient's situation'. In cases where the source of the suffering is a physiological disorder, the patient's reasonable decision to refuse a realistic treatment possibility (whether curative or palliative) which might ease his or her suffering does not stand in the way of a request for euthanasia based on that suffering.

In Belgium, the 'patient [must be] in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident'. Like the Netherlands, there is no requirement that the patient be suffering from a terminal illness, although additional procedural requirements are imposed if the patient is 'clearly not expected to die in the near future'. Again there must be 'no reasonable alternative' to euthanasia. However, euthanasia is permissible only if the disorder is incurable, so a patient's reasonable refusal of potentially curative treatment will

prevent access to euthanasia.[23] The reasonable refusal of a palliative treatment possibility will not have this effect.

The Netherlands permits assisted suicide in cases where the source of the patient's suffering is a psychiatric rather than a physiological disorder. In such cases, the patient may not reject 'a realistic alternative to relieve the suffering'.[24] In Belgium, the permissibility of euthanasia or assisted suicide in psychiatric cases was initially unclear, but such cases have been accepted by the CFCE.[25]

In Oregon, the patient must be suffering from a terminal disease, defined as 'an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months'. There is no additional requirement relating to the patient's experience of the disease or any minimum level of suffering.

In principle, selfless suicide assistance is lawful in Switzerland irrespective of the condition of the individual who dies. However, the supply of barbiturates is subject to federal narcotics law, which permits physicians only to administer, dispense or prescribe lethal medication within the limits of accepted professional and scientific practice.[26] This requirement is reiterated in cantonal health law.[27] The Swiss Academy of Medical Sciences (SAMS) has outlined what constitutes accepted practice in respect of suicide assistance in its medical ethical guidance,[28] which, although not legally binding, 'play[s] an important role in a number of cantonal health laws, and [is] often referred to in the case law'.[29]

The Swiss physician must personally examine the individual seeking assistance to 'assess the medical condition(s) giving rise to the desire to die'.'[30] Previously, 'a condition indisputably leading to death' was held to be a requirement of accepted practice.[31] This requirement was subsequently enshrined in the SAMS guidance, which sets as one of the preconditions for physician assistance that 'the patient's disease justifies the assumption that he is approaching the end of life'.[32] However, in 2006 the Federal Supreme Court held that 'a serious, incurable and longstanding mental disorder could cause an individual to suffer to the extent that he no longer regarded his life worth living'.[33] Therefore, it may be lawful to

prescribe lethal medication to mentally disordered individuals, provided they meet certain additional criteria (see 'Request', below).[34]

### Request

In the Netherlands, the patient's request must be 'voluntary and carefully considered'. The patient must be competent to make such a request and the attending physician must consult a psychiatrist if he or she suspects the patient is incompetent.[35] The request must also be well informed. The statute does not require that the request be in writing but it has long been considered good practice to obtain a written request.[36] The statute does allow termination of life on *advance* request, if a competent person becomes incompetent after having made a 'written declaration requesting that his life be terminated' that complies with the due care criteria.[37]

In Belgium, the patient must be 'legally competent'. The request must be both 'completely voluntary' and 'not the result of any external pressure'. The physician must inform the patient about 'his health condition and life expectancy' and 'the possible therapeutic and palliative courses of action and their consequences'. The patient's request must be in writing. A request may be made in advance, but since the triggering condition is unconsciousness, advance requests will not be applicable to many scenarios of future incompetence, including dementia.[38]

In Oregon, the competence, voluntariness and information requirements are set out in some detail. The patient must have 'the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available'. The request must be in writing. Two witnesses must attest that the patient is acting voluntarily and is not being coerced to sign the request. The patient must make an

informed decision… that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of: (a) his or her medical diagnosis; (b) his or her prognosis; (c) the potential risks associated with taking the medication to be prescribed; (d) the probable result of taking the medication to be prescribed; (e) the feasible

alternatives, including, but not limited to, comfort care, hospice care and pain control.[39]

In Switzerland, the person who is assisted with suicide must have capacity in order for their act to be considered suicide.[40] The courts have also used the national narcotics law to impose criteria related to the patient's request (see 'Condition and/or experience of suffering', above). The physician must personally examine the person seeking assistance and assess their capacity, the test for which is set out in the Civil Code.[41] The right to die association Exit ADMD has developed its own questionnaire, based on a validated test for capacity to make advance directives, which is designed to determine whether an individual seeking suicide assistance has capacity.[42]

### Age

The Dutch law applies also to patients under the age of majority (18). A patient between the ages of 16 and 18 who is 'capable of making a reasonable appraisal of his own interests' may request euthanasia or assisted suicide. The parent(s) or guardian does not have a veto, but must be consulted. Patients aged between 12 and 16 must pass the same test of capacity. In addition, the consent of the parent(s) or guardian is required.

In Belgium, euthanasia is legal only for patients over the age of 18 and for minors over the age of 15 who have been legally emancipated by a judicial decision. The Oregon and Luxembourg laws apply only to patients over the age of 18. Children cannot have the required legal capacity to commit suicide in Switzerland, but the position of adolescents is unclear.[43]

### Consultation and referral

In the Netherlands, an independent physician must see the patient and give a written opinion on the extent to which the due care criteria are met. The consultation requirements are more stringent if the patient's suffering is the result of a psychiatric disorder.[44] The state funded programme Support and Consultation on Euthanasia in the Netherlands (SCEN) trains physicians to be consultants and to provide support and advice for physicians treating patients at the end of life. Most reported euthanasia cases involve a SCEN

consultant.[45] A non-binding protocol containing guidelines for good consultation has been implemented among SCEN consultants.[46]

In Belgium, the consulting physician must examine the patient and their medical records, and ensure that the suffering requirement has been met. Moreover, if the patient 'is clearly not expected to die in the near future', there is a mandatory additional consultation with either a psychiatrist or relevant specialist (and a waiting period of at least one month). Life End Information Forum (LEIF), a service similar to the Dutch SCEN service, has recently been developed in Flanders. LEIF consultants are trained using guidelines based on the SCEN protocol.[47] Most LEIF consultants have undertaken additional training in end of life care, and have experience caring for incurably ill patients.[48] Although a consultation with a palliative care expert is not legally required, many Catholic hospitals in Flanders impose such a palliative filter in addition to the statutory criteria.[49] The Belgian law also requires discussion of the patient's request for euthanasia with the nursing team involved in caring for the patient.

In Oregon, the attending physician is required to refer the individual requesting physician assisted suicide to a consulting physician, 'who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease',[50] and to determine that the patient is capable and acting voluntarily. There is no requirement in the DWDA that the consulting physician be independent from the attending physician – that there be no professional or other relationship between the two. Further, a counselling referral must be made if either the attending or consulting physician suspects that the patient 'may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment'. Physician assisted suicide is allowed only if the counsellor determines that the patient is not suffering from such a condition. The substantive aspect of this requirement does not distinguish between cases in which judgement is impaired but capacity is not. A measure to amend the DWDA in favour of a presumption that individuals requesting physician assisted suicide were mentally disordered recently failed in the Oregon legislature.[51] There is no requirement in the DWDA that individuals experience

palliative care before receiving a prescription for physician assisted suicide. However, Compassion and Choices of Oregon, a patient advocacy organisation that assists individuals in making end of life decisions (including assisting individuals who seek physician assisted suicide), 'makes referrals to hospice a primary feature of its patient care counselling'.[52] Thus, it may be that 'hospice programs are regarded as an important societal mechanism to assure [*sic*] that physician-assisted death is practiced responsibly'.[53]

The Swiss right to die organisations each follow an internal protocol, which will determine whether an individual meets the organisation's criteria for suicide assistance.[54] Once this initial selection process has been completed, contact is made with a physician, preferably the individual's general practitioner, who will then independently verify whether the patient meets the criteria for assisted suicide.[55] Since 2008, physicians in Zurich are required to meet the individual seeking suicide assistance in person on two occasions before a prescription is issued.[56] If the individual contacts his physician first, and a right to die organisation subsequently, then this process may occur in reverse. In acute care hospitals that have implemented a protocol for assisted suicide, consultation may occur either when the individual is discharged and contacts a right to die organisation, or if the suicide is to take place in the hospital, with a representative of the hospital ethics committee.[57]

### Assistor

In the Netherlands, during the development of the defence of necessity by the courts, it was held that only physicians can face the conflict of duties because only physicians have a professional duty to relieve suffering: lay persons (who include relatives) and nurses do not. The courts originally required that the person providing euthanasia was the patient's treating physician.[58] The current requirement focuses more closely on its purpose: the physician must know the patient sufficiently well to be able to assess whether the due care criteria are met.[59]

The Belgian act requires that the physician have 'several conversations with the patient spread out over a reasonable period of time' in order to be certain of the persistence of the patient's suffering and the enduring character of his or her request. The

Dutch purpose focused argument (that in order to assess whether the due care criteria are met, the physician must have some familiarity with the patient) might also be applied in Belgian euthanasia cases. However, the legislative history makes clear that the patient should be able to bypass his or her attending physician if so desired – from which one might infer that there is no requirement for a pre-existing physician–patient relationship.[60]

In Oregon, the attending physician is defined as 'the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease'. There is no requirement that the patient have a longstanding relationship with the attending physician before the prescription of lethal medication.

The laws in Belgium and Oregon contain conscientious objection provisions. Although there is no such provision in the Dutch law, it is nonetheless clear that 'no doctor has any obligation to accede to a request [for euthanasia], however well founded'.'[61]

In Switzerland, there is no legal criterion that relates to the identity of the assistor: in the absence of selfish motives, any individual may in principle assist in the suicide of another.

### Due medical care

In the Netherlands, one of the due care criteria requires the physician to have terminated the patient's life or provided assistance with suicide with due medical care and attention. A list of appropriate medications is provided by the Royal Dutch Pharmacological Association (KNMP),[62] and deviation from this list – for example, by the use of morphine – is almost always found by the regional review committees to be a breach of this criterion of due care unless there are exceptional circumstances; for example, the patient's desire for a slow death. Other departures from the KNMP guidance – such as the use of lower dosages of approved euthanatica – have been found 'not careful' by the regional review committees[63] but defended on medical grounds by some of the physicians involved.[64]

The criterion of due medical care and attention also requires the physician's continuous presence during the euthanasia or assisted suicide in case further medical intervention is required. 'This

requirement… has been reaffirmed in guidelines of the medical profession and in decisions of the Regional Review Committees.'[65] In cases of assisted suicide, the physician must be prepared to perform euthanasia if there are any problems with the assisted suicide; for example, if the patient remains in a coma for a lengthy period or vomits the medication.[66] This requirement also ensures that the medication to be used remains under the control of the physician. The requirement of physician presence is sometimes challenged in cases of assisted suicide, on the grounds that the pressure of an appointment with the physician may make the patient hesitate to defer his decision.[67] (Although this is also true in euthanasia cases, such pressure is potentially avoidable in assisted suicide cases.) From 2005 to 2007, the regional review committees accepted the possibility that for good reasons, in an exceptional case of assisted suicide, an advance agreement could be made that the physician would not be present but would continuously be available to intervene.[68] This exception has been removed from the relevant section of the 2008 and 2009 annual reports.[69]

The Belgian law does not include a provision requiring that the physician exercise due medical care when carrying out euthanasia. Such a requirement was considered by the legislature during the debates over the bill, but was thought to be unnecessary since all medical procedures must be carried out with due care. In the absence of such a requirement, the CFCE has been reluctant to develop rules on the physical presence of the physician or the medications which must be used in euthanasia cases.[70] The guidance to physicians issued by the CFCE admits the possibility that morphine may be used for these purposes, despite (as the CFCE itself admits) the medical evidence demonstrating that this is not the best medication with which to achieve a death that is calm, rapid and without suffering.[71]

The Oregon act permits only the provision of a prescription for lethal medication to be self-administered by the patient. No due care criterion is included, although a separate provision requires the physician to fulfil certain medical record documentation requirements.[72]

In principle, any form of suicide assistance is permissible in Switzerland. However, in almost all cases suicide assistance involves a prescription of the barbiturate sodium pentobarbital,[73] which is then administered in the presence of a volunteer from one of the 'right to die' organisations. Physicians prescribing lethal medication must act in accordance with accepted medical practice (see 'Condition and/or experience of suffering', above).[74] Volunteers of the right to die organisations provide support to the individual who dies and manage complications.[75] It has been suggested that it may be preferable to have volunteer assistance during the final act insofar as the assistance of 'a nurse with special training and experience in this field [may be preferable to that of] a general practitioner who has no particular training and has never engaged in assisted suicide before'.[76]

Dignitas, a Swiss 'right to die' organisation, has recently assisted a number of suicides by means of oxygen deprivation with helium.[77] Since helium is not subject to regulatory restriction, its use effectively removes a procedural safeguard, insofar as it is no longer required that assisted suicides be subject to accepted medical practice. However, the internal protocols of the right to die organisations would still apply in such suicides.[78]

### Reporting and scrutiny

Termination of life on request and assisted suicide remain criminal offences in the Netherlands. The defences inserted into the Penal Code by the 2001 act require the physician to report the case as euthanasia or assisted suicide to the municipal pathologist, who then passes the file to the relevant regional review committee. If that committee finds that the physician did not act in accordance with the due care criteria, the case is referred to the Public Prosecution Service. Between 1999 and 2009 47 cases were referred (0.21 per cent of reported cases). No prosecutions have been brought following these referrals.[79]

Compliance with the Belgian law is monitored by the CFCE, to which all cases of euthanasia must be reported. No cases have been reported to the prosecutorial authorities by the CFCE.

In Oregon, the physician must report each prescription written under the act to the Oregon Department of Human Services (ODHS), and report each death resulting from the ingestion of the prescribed medication. At least 22 physicians have been referred by the ODHS to the state Board of Medical Examiners; most of these cases involved incorrectly completed forms.[80]

In Switzerland, assisted suicides must be reported as unnatural deaths to the local authorities. There is no national body to which assisted suicides must be reported and thus no national reporting data are available.[81] The lack of independent or judicial oversight of assisted suicide has been a subject of concern outside Switzerland.[82] However, the Swiss Federal Council has recently rejected additional specific criminal law provisions relating to organised assisted suicide.[83]

# PART 2 DETAILED EVALUATION OF SAFEGUARDS PRESENT IN ASSISTED DYING REGIMES

## METHODOLOGY

Safeguards are evaluated against recent empirical evidence from official and academic sources, as well as a selection of articles reviewing empirical data. The four target jurisdictions are treated in sequence using the headings utilised in the preceding section:

- type of assistance
- condition and/or experience of suffering
- request
- age
- consultation and referral
- assistor
- due medical care
- reporting and scrutiny

## THE NETHERLANDS

### Type of assistance

Since Dutch law does not restrict assistance only to physician assisted suicide, but permits euthanasia, the effectiveness of a restriction to physician assisted suicide is not discussed here.

Only one neonatal case of termination of life without request has been reported (in 2009) since the national reporting committee for neonatal termination of life was established.[84] (Interestingly, 22 neonatal cases were reported to prosecutors between 1997 and 2004.[85]) No equivalent regime exists for other cases of termination of life without request. While data exist on the number of such cases overall,[86] specifically for children[87] and for neonates,[88] in the absence of a regulatory regime it is not possible to evaluate the extent to which criteria are adhered to in such cases.

### Condition and/or experience of suffering

National data relating to the reasons for ungranted requests for euthanasia provide some evidence about the application of the requirement that the patient was experiencing unbearable suffering with no prospect of improvement. In 2005, 29 per cent of all concrete requests were carried out.[89] Again in that year, physicians cited the absence of unbearable suffering as the reason for not granting the request in 16 per cent of ungranted requests[90] (approximately 11 per cent of all concrete requests) and the absence of hopeless suffering[91] as the reason for not granting the request in 8 per cent of ungranted requests[92] (approximately 6 per cent of all concrete requests). A 2005 study of granted and ungranted requests among Dutch GPs found that when the GP's view was that the patient was experiencing unbearable suffering 'to a lesser extent', the GP was 15 times more likely to refuse than to grant the request.[93] When the GP's view was that the patient was experiencing hopeless suffering 'to a lesser extent', the GP was 11 times more likely to refuse than to grant the request.[94] Also relevant to the presence of hopeless suffering, if alternative treatments were available, the GP was 4.4 times more likely to refuse than to grant the request.[95]

In a recent study of reported cases from 2007 to 2009, the regional review committees found that the unbearable suffering criterion was not met in only two out of 7,487 cases. In these cases, the patient had lost consciousness by the time of the euthanasia or at the time of the examination by the consulting physician.[96]

The lack of unbearable suffering is the main reason for SCEN consultants finding that the due care criteria have not been met in approximately two-thirds of cases in which such a finding is made.[97] A decision that the patient's suffering is not hopeless is made in approximately 10 per cent of such cases.[98] Finally, SCEN consultants conclude that alternative treatments are available in between a tenth to a quarter of cases in which they find that the due care criteria are not met or are yet to be met.[99]

The presence of depression is relevant to the question whether the patient's suffering has no prospect of improvement. Depression is significantly less prevalent in granted requests than in refused

requests. Using the 2005 national data, one study examined the presence of depressive symptoms during the last 24 hours of life, finding that depressive symptoms were present in 12 per cent of cases of ungranted requests for euthanasia and 2 per cent of cases of granted requests for euthanasia,[100] a trend also found in other studies.[101] A recent study into depression and explicit requests for euthanasia or assisted suicide among 64 cancer patients in primary care found that:

[N]one of the patients with an explicit EAS [euthanasia or assisted suicide] request [N = 17] suffered from a definite major depression… Furthermore, no relationship was found between depressed mood and explicitly requesting EAS. This outcome was based on results from the HADS [Hospital Anxiety and Depression Scale] (all scales), as well as the single-item depression screener.[102]

There appears to be no significant difference between reported and unreported cases on the issue of the presence of either unbearable or hopeless suffering.[103]

### Request

In a recent study of reported cases from 2007 to 2009, the relevant regional review committee found that the physician had met the criteria related to the request in all 7,487 cases.[104]

### Capacity

'[T]he problem of competence of patients suffering from a somatic disorder has received relatively little attention.'[105] National data relating to the reasons for ungranted requests for euthanasia provide some indication of the way in which the competence criterion is applied. In 2005, 29 per cent of all concrete requests were carried out.[106] Again in that year, physicians cited a lack of a well-considered request as the reason for not granting the request in 18 per cent of ungranted requests[107] (approximately 13 per cent of all concrete requests). A 2005 study of granted and ungranted requests among Dutch GPs found that when the patient lacked full capacity, the GP was 21 times more likely to refuse than to grant the request.[108]

For SCEN consultants, the lack of a well-considered request is the main reason for finding that the due care criteria have not been met in approximately 30 per cent of cases in which such a finding is made.[109]

Depression, which may affect competence, is significantly less prevalent in granted requests than in refused requests. Using the 2005 national data, one study examined the presence of depressive symptoms during the last 24 hours of life, finding that depressive symptoms were present in 12 per cent of cases of ungranted requests for euthanasia, and 2 per cent of cases of granted requests for euthanasia,[110] a trend also found in other studies.[111] As noted above in the discussion of the relation between depression and suffering, a recent study into depression and explicit requests for euthanasia or assisted suicide among cancer patients in primary care found that:

[N]one of the patients with an explicit EAS [euthanasia or assisted suicide] request suffered from a definite major depression… Furthermore, no relationship was found between depressed mood and explicitly requesting EAS. This outcome was based on results from the HADS [Hospital Anxiety and Depression Scale] (all scales), as well as the single-item depression screener.[112]

Although guidelines require the attending physician to consult a psychiatrist if he or she suspects the patient is incompetent,[113] psychiatric consultation is rare, particularly if the patient's primary physician is not a psychiatrist.[114]

### Voluntariness

National data relating to the reasons for ungranted requests for euthanasia provide some indication of the way in which the voluntariness criterion is applied. In 2005, 29 per cent of all concrete requests were carried out.[115] Again in that year, physicians cited a lack of a voluntary request as the reason for not granting the request in 6 per cent of ungranted requests[116] (approximately 4 per cent of all concrete requests). SCEN consultants find in a relatively small number of cases (3.6–6.5 per cent) that the due care criteria have not been met as a result of a lack of voluntary request.[117]

### Information provision

There is no evidence of the extent to which the information provision requirement is met in the Netherlands beyond the evidence that the regional review committees find no problem with requests in reported cases.[118]

#### Written request

The regional review committees encourage written requests although the statute does not demand them. They appear to be present in almost all cases,[119] with those few cases in which they are not present receiving close attention from the regional review committees.[120]

### Age

No regional review committee judgments involving patients younger than 30 have been posted on the official website, although only selected judgments are ever posted. The regional review committees' annual reports have only discussed one case of euthanasia involving a minor (a 12-year-old suffering from cancer); the committee decided that the physician had acted in accordance with the due care criteria.[121]

Termination of life without request is discussed above in the section 'Type of assistance'.

### Consultation and referral

#### Consultation with another physician

In a study of reported cases from 2007 to 2009, the regional review committees found that the consultation criterion was not met in only 11 out of 7,487 cases.[122] In eight of these cases the consulting physician was not sufficiently independent of the treating physician.[123] In two of the cases no consultation had been undertaken,[124] and in one case there was a five-month delay between the consultation and euthanasia.[12]

In 2009, in one in four cases that came before SCEN consultants, the consultant decided that the due care criteria had not been or were not yet fulfilled.[126] Among 433 SCEN consultations that had taken place in 2002 (corresponding to each consultant's last consultation for that year), euthanasia took place in 59.4 per cent of cases, with euthanasia being performed in only 2.3 per cent of cases where the SCEN consultant had given a negative opinion in respect of the request.[127] Significantly, where the attending physician had a

negative *a priori* position toward the euthanasia request (in 5.6 per cent of all cases), a SCEN consultation nevertheless took place. Perhaps unsurprisingly, given the attending physician's negative *a priori* position towards the request, euthanasia was not administered in any of these cases, including the 20.8 per cent of cases in which the SCEN consultant gave positive advice about the request.[12]

None of the SCEN consultants were a co-attending physician of the patient, 95.2 per cent of consultants did not work in the same practice as the attending physician, and 97.2 per cent did not know the patient.[129] The consultations with the attending physician primarily took place over the telephone (96.4 per cent), with only 37.9 per cent of the SCEN consultants discussing the case face to face with the attending physician.[130] In 83.7 per cent of cases the SCEN consultant talked with the patient in person, although only 11.9 per cent examined the patient physically.[131] In 87.7 per cent of cases, the consultant discussed the well-considered nature of the request with the attending physician; in 95.1 per cent of cases the consultant discussed the patient's unbearable suffering; and 93.9 per cent of cases studied the patient's medical records.[132] SCEN consultations took on average 3 hours and 50 minutes,[133] (although this includes travel time, the average length of which is unknown).[134] The consultations were judged by attending physicians to be of good quality in 97.2 per cent of cases.[135] The positive evaluation of SCEN consultations is supported by previous research, which found that 'SCEN physicians more frequently meet the criteria for good consultation and GPs attach some more importance to consultant's judgement when the consultant is a SCEN physician'.[136]

In 1995 in unreported cases (variously reported as 11 per cent or 21 per cent), consultation was far less frequent than in reported cases (variously reported as 94 per cent or 99 per cent).[137]

## Assistor

### Involvement of nurses

Although only physicians can legally practise euthanasia and physician assisted suicide, there is evidence of nurses' involvement, including in the administration of euthanatica, which is clearly not

permitted.[138] One recent study found that in almost 3 per cent of cases a nurse or a nurse anaesthetist had administered euthanatica.[139] A smaller sample study (n=359) found that nurses were more likely to be consulted by the physician in cases where euthanasia was granted (81.4 per cent) than (71.6 per cent) where it was not.[140] Of 143 cases where a nurse was present during administration, in 3.5 per cent the nurse administered the euthanatica, and in 11.9 per cent the nurse administered the euthanatica with the physician.[141]

### Relationship with patient

Although rare, cases in which there is no pre-existing physician–patient relationship are closely investigated. In 2005, for example, a case was reported to the prosecutorial authorities by the relevant regional review committee on the grounds that the physician, an acquaintance of the patient, did not have a sufficiently strong treatment relationship with the patient.[142]

### Conscientious objection

The existence of an implicit right to conscientious objection in the Netherlands is confirmed by the data from the national reports indicating that a small but fairly stable percentage of Dutch physicians are unwilling to perform euthanasia (15 per cent in 2005; 11 per cent in 2001; 12 per cent in 1995; 12 per cent in 1990). A majority of these physicians would refer a patient who requests euthanasia to another physician (14 per cent overall in 2005, which is 93 per cent of physicians who are unwilling to perform euthanasia).[143]

## Due medical care

In a recent study of reported cases from 2007 to 2009, the regional review committees found that the due medical care criterion was not met in only nine out of 7,487 cases.[144] In five of these cases[145] the dose of sedative was lower than that required in the Royal Dutch Pharmacological Association (KNMP) guidance.[146] In another case the physician had not ascertained the depth of the patient's coma before administering the muscle relaxant.[147] In one case the physician was found to have breached the requirement of due medical care and attention when he was not present during his patient's assisted suicide;[148] in another, in accordance with an

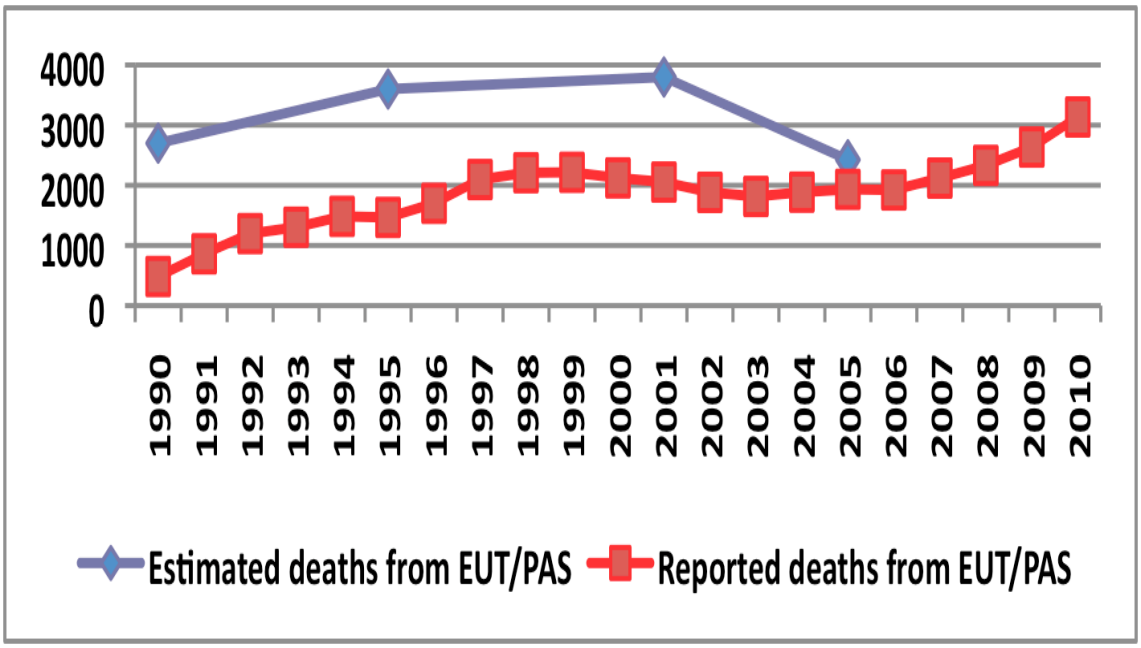
explicit request by the patient and in the presence of the physician, the patient and his partner had injected the euthanatica into the patient's percutaneous endoscopic gastrostomy (PEG) tube.[149] In one case the physician had refused to provide information about the doses used.[150]

The 1995 data showed no significant difference in the rate of problems with medications used between reported and unreported cases.[151]

### Reporting and scrutiny

Figure 1 shows that more and more deaths from euthanasia came to be reported as the Dutch control system became established, and that the Dutch reporting rate has improved significantly over time.[152]

Figure 1 Estimated and reported deaths from euthanasia or physician assisted suicide in the Netherlands




The latest Dutch reporting rate (from 2005) is 80 per cent: 'The major reason for failure to report [a case as euthanasia] is that the physician does not regard the course of action as a lifeterminating act.'[153] These unreported cases frequently involve the use of non-typical drugs to cause death (morphine rather than barbiturates

and/or muscle relaxants) and/or a very short life expectancy.[154] The number of *estimated* deaths from euthanasia includes such cases, since it does not rely on physicians' labelling of their own practice. Since 99 per cent of cases involving typical euthanasia drugs are reported,[155] this inconsistent labelling is now likely to account for most unreported cases. This thesis is supported by data collected on physicians' willingness to report euthanasia. Of physicians who stated that they had performed euthanasia since the 2002 act, 97 per cent stated that they had always reported it.[156]

## BELGIUM

### Type of assistance

Since Belgian law does not restrict assistance only to physician assisted suicide, but permits euthanasia, the effectiveness of a restriction to physician assisted suicide is not discussed here.

There are a number of sources of prevalence data on termination of life without request. The Sentinel Network Study Monitoring End-of-Life Care Study (SENTI-MELC) involved a network of general practitioners who reported on patient deaths in 2005/06 and categorised these as sudden or non-sudden. For the latter, data were collected on end of life decisions under the same framework used in the Dutch national surveys and the earlier Belgian studies.[157] The rate of euthanasia was found to be 1.6 per cent in Flanders and 1.3 per cent nationally,[158] more consistent with the pre-legalisation rate found in 1998 (1.1 per cent in Flanders (95% confidence interval (CI) 0.9% to 1.5%))[159] than the lower pre-legalisation 2001/02 European End of Life Decisions (EURELD) Consortium rate of 0.3 per cent in Flanders (95% CI 0.16% to 0.58%)[160] and the rates of reported cases for 2008/09 (0.7 per cent of all deaths), 2006/07 (0.44 per cent) and 2004/05 (0.36 per cent).[161] However, the numbers are very small, and it is also possible that the rate of euthanasia rose after legalisation while the rate of termination of life on request decreased.[162] The 2005/06 SENTI-MELC rate is also consistent with that found in a 2007 study of death certificates in Flanders, in which the estimated rate of euthanasia was 1.9 per cent of all deaths (95% CI 1.6% to 2.3%).[163]

In the 2005/06 SENTI-MELC study, the rate of termination of life without request was 1.6 per cent nationally (1.7 per cent in Flanders).[164] In the 2007 death certificate study in Flanders, the rate of termination of life without request was 1.8 per cent (95% CI 1.3% to 2.4%).[165] The incidence of termination of life without request in the study by the EURELD Consortium in 2001/02 was 1.5 per cent in Flanders (95% CI 1.12% to 2.01%).[166]

A recent study based on the 2005/06 SENTI-MELC findings interviewed 13/17 (76.4 per cent) of the general practitioners who had administered life-ending drugs without request to a patient at home or in a care home.167 All of the patients to whom lethal medication had been administered without request 'were completely bedridden and incapable of self-care, and all but one (92.3 per cent) were unconscious or in a coma for one or more hours or days before death, and all experienced [principally physical] symptoms'.168 At the time of the life-ending decision, 'the GP judged the medical situation of all thirteen patients as without any prospect of improvement', of which 'nine [69.2 per cent] were considered to suffer persistently and unbearably to a high or very high degree'.169 One (7.7 per cent) of the patients had decisional capacity and had previously expressed a wish 'not to suffer anymore although this wish was not an explicit request to hasten death'.170 The decision to end this individual's life was taken after discussion with relatives and professional caregivers.171 Among the 12 individuals (92.3 per cent) without capacity who received life-ending medication, three had expressed a wish bearing 'upon life ending'.172 In seven cases (53.8 per cent), the physician had discussed the decision with relatives and professional caregivers; in four cases (30.8 per cent) the physician had discussed the decision with relatives only, and in one case (7.7 per cent) the decision had been taken after consultation with a professional caregiver only, since the individual concerned had no family.173

### Condition and/or experience of suffering

In a study of the CFCE database of all reported cases from 2002 to 2007, Smets et al found that suffering was reported in all but 22 of 1,917 reported cases (98.9 per cent).[174] In seven of those 22 cases, the patient was comatose (and euthanasia was performed on the

basis of an advance request). For the remaining 15 patients, the information on suffering was missing and the researchers were not able to discover whether the CFCE had sought further information from the physicians involved.[175]

In the 2005/06 SENTI-MELC study, interviews were conducted with GPs who had performed euthanasia for patients at home:

All patients (n = 9) were in a condition for which medical treatment was unavailing and there was no prospect of improvement. Most experienced lasting and unbearable physical and/or psychological suffering (n = 8); one patient (case 4) was not suffering unbearably at the end of the decision-making process, but unbearable suffering was expected in the future… In all cases, the GP informed the patient about their health condition and life expectancy and in all cases they had together come to the conclusion that no more reasonable alternative treatments were possible. Sometimes the GP indicated that life-prolonging (n = 3) or palliative treatments (n = 4) were still possible, but they were not applied because the patient refused further treatment or did not want to prolong their life, or because the patient or physician deemed the chance for improvement too small.[176]

A recent interview study of GPs involved in the 2005/06 SENTI-MELC research found that 1/8 (12.5 per cent) of the patients refused euthanasia notwithstanding an explicit and repeated request did not meet the criterion of unbearable and persistent suffering. Among patients whose wish for euthanasia was judged not to be explicit and repeated, 3/14 (21.4 per cent) patients were also judged not to have unbearable and persistent suffering.[177]

The presence of depression is relevant to the question whether the patient's suffering has no prospect of improvement. Unfortunately, there is no evidence of the prevalence of depression in granted or ungranted requests for euthanasia in Belgium.

### Request

#### Capacity

In a study of the CFCE database of all reported cases from 2002 to 2007, Smets et al found that a well-considered request was present in 100 per cent of cases, 97.9 per cent involved a current request and the remaining 2.1 per cent involved an advance request.[178] In

the 2005/06 SENTI-MELC study, all of the patients who received euthanasia whose GP was interviewed (n = 9) had made a well-considered request for euthanasia.[179]

The presence of depression is relevant to the question whether the patient is competent. Unfortunately, there is no evidence of the prevalence of depression in granted or ungranted requests for euthanasia in Belgium.

### Voluntariness

In a study of the CFCE database of all reported cases from 2002 to 2007, Smets et al found that a voluntary request was present in 100 per cent of cases; 97.9 per cent involved a current request and only 2.1 per cent involved an advance request.[180] In the 2005/06 SENTI-MELC study, all of the patients who received euthanasia whose GP was interviewed (n = 9) had made a voluntary request for euthanasia.[181]

### Information provision

In the 2005/06 SENTI-MELC study, 100 per cent of the patients who received euthanasia whose GP was interviewed (n = 9) had been informed about their health condition and life expectancy.[182]

### Written request

The 2007 death certificate study in Flanders found that in cases of euthanasia where physicians stated that they had reported to the CFCE, the required written request was present in conjunction with an oral request in 73.1 per cent of cases (95% CI 56.8% to 84.9%), and alone in an additional 9.3 per cent of cases (95% CI 2.4% to 29.9%). In unreported cases, a written request was present in conjunction with an oral request in only 8.6 per cent of cases (95% CI 3.9% to 18.0%), and alone in an additional 3.7 per cent of cases (95% CI 0.9% to 14.5%).[183] In a study of the CFCE database of all officially reported cases from 2002 to 2007, Smets et al found that a written request was present in 100 per cent of cases, with 97.9 per cent involving a current request and only 2.1 per cent involved an advance request.[184] The 2002–2007 CFCE study suggests that the rate of written requests in reported cases falls within the upper reaches of the 95 per cent confidence intervals associated with the rates of written requests in the 2007 death certificate study: the rate is likely to be close to 100 per cent.

In the 2005/06 SENTI-MELC study, 89 per cent of the patients who received euthanasia whose GP was interviewed (n = 9) had made a written request for euthanasia.[185]

### Age

The reports of the CFCE reveal only four cases involving a patient under the age of 20, with no reported cases involving minors.186 In the 2005/06 SENTI-MELC study, all of the patients who received euthanasia whose GP was interviewed (n = 9) were adults.187 The 2007 death certificate study in Flanders reported no cases involving patients under the age of 18.188 A recent death certificate study in Flanders (data from 2007 to 2008) revealed a null rate for euthanasia and assisted suicide for patients between the age of 1 and 17 (the rate of termination of life without request in this group was 7.9 per cent (95% CI 5.8% to 10.7%).189

## Consultation and referral

### Consultation with another physician

The 2007 death certificate study in Flanders found that consultation with another physician occurred in almost all reported cases (97.5%, 95% CI 88.1% to 99.5%) but in far fewer unreported cases (54.6%, 95% CI 38.7% to 69.6%).[190] In the same study, consultation took place with another physician in 77.8 per cent of all euthanasia cases, and in 58.4 per cent of cases of termination of life without request.[191]

In a study of the CFCE database of all reported cases from 2002 to 2007, Smets et al found that a second independent physician had been consulted in 99.8 per cent of all reported cases.[192] In those cases in which an additional consultation was required (because the patient was not expected to die in the near future), that additional consultation took place in 100 per cent of such cases.[193]

A survey questionnaire (n = 363) conducted in 2009 found consultation with an independent physician to have occurred in 64.7 per cent of euthanasia requests, and euthanasia to have been administered in 86.5 per cent (148/171) of cases after consultation.[194] Euthanasia occurred in 78 per cent (140/180) of cases where the independent physician gave positive advice, 10 per cent (4/45) of cases where the independent physician gave negative

advice, and 59 per cent (4/7) of cases where no advice had been given at the time of life-ending conduct.[195] Euthanasia occurred in 17 per cent (20/123) of cases where no consultation had taken place.[196] The response rate for the survey was 34 per cent, thus the results should be treated with caution.[197]

Between May and September 2008, for 311 consultations, LEIF consultants found the criteria for euthanasia not to be met in 8.4 per cent of patients.198 This compares with 4.96 per cent (18/363) of rejected requests after consultation for all independent consultants during 2009.199 Among 69 LEIF consultations that had taken place between May 2007 and May 2008200 euthanasia took place in 69.6 per cent of cases, with euthanasia being performed in no cases where the LEIF consultant had given a negative opinion on the request.201 The attending physician had a negative a priori position to the request in 13 per cent (9/69) of cases.202 Nevertheless, a LEIF consultation took place in these cases, and favourable advice in favour of the euthanasia request was given in 66.7 per cent (6/9) of cases, with 22.2 per cent (2/9) resulting in euthanasia.203

Attending physicians had returned 40 questionnaires (response rate 58 per cent) describing the consultation and evaluating the quality of the consultation.[204] None of the LEIF consultants was a co-attending physician of the patient; 95 per cent of consultants did not work in the same practice as the attending position; and 92.5 per cent did not know the patient.[205] The consultations primarily took place over the telephone (90 per cent), although many consultants (62.5 per cent) also discussed the request with the attending physician face to face.[206] In 97.5 per cent of cases the LEIF consultant talked to the patient, and 40 per cent of consultants examined the patient physically.[207] In 90 per cent of cases the consultant discussed the hopelessness of the medical situation with the attending physician; in 77.5 per cent of cases the consultant discussed the well-considered nature of the request; in 65 per cent of cases the consultant discussed the patient's unbearable suffering; and 80 per cent studied the patient's medical records.[208] LEIF consultations took on average 3 hours and 15

minutes,[209] and were judged by attending physicians to be of good quality in 98.4 per cent of cases.[210]

In the 2005/06 SENTI-MELC study, of all the patients who received euthanasia whose GP was interviewed (n = 9), the rate of consultation was 66.7 per cent:

In three cases the physician did not consult a second physician as required by law. One of these physicians (case 7) did not find this sort of consultation necessary because they did not consider it a clear case of euthanasia. Another (case 9) did not consider a consultation because it 'was a case of euthanasia outside the euthanasia law. No lethal drug was used.' These two physicians, however, did consult other physicians who, while not performing the tasks required by the law, gave advice and information. One physician (case 8) did not consult another physician at all because they found the legal consultation procedure too burdensome and not useful, and believed it was 'up to the patient and physician alone to make the decision'.[211]

### Discussion with nursing team

In two of the six cases in which consultation took place, the consultant was not independent of the physician who performed euthanasia.[212]

A 2001 pre-legalisation survey of Belgian physicians based on death certificates found that discussion of the patient's request for euthanasia with the nursing team varied according to the place of care. Euthanasia requests were discussed with the nursing team in 100 per cent of cases which took place in an institution, but in only 41.1 per cent of cases which took place at home.[213] The corresponding figures for termination of life without request were 71.7 per cent (institution) and 50.9 per cent (home). The post-legalisation 2007 death certificate study in Flanders reported that physicians had discussed the request with the nursing team in 54.1 per cent of euthanasia cases and 40.2 per cent of cases of termination of life without request.[214] A recent survey of nurses (data from 2007) found that nurses were involved in decision-making in 64 per cent of euthanasia cases and 69 per cent of cases of termination of life without request.[215]

In the 2005/06 SENTI-MELC study, of all of the patients who received euthanasia whose GP was interviewed (n = 9), the rate of discussion with nurses and/or a palliative care team was 66.7 per cent.[216]

### Involvement of LEIF physician

For 311 instances where a LEIF physician provided the independent consultation, in 37 per cent (115/311) of cases the consultant was present during the performance of euthanasia; in 26.7 per cent (83/311) of cases the consultant helped with preparation; and in 23.5 per cent (73/311) cases the consultant administered the euthanatica in the presence of the attending physician.[222] Although Belgian law does not require the attending physician to perform euthanasia, 'the roles between the attending physician and the consultant are not intended to be reversed

when the former does not want to perform euthanasia'.[223]

### Relationship with patient

No data exist in Belgium on the nature or length of the physician–patient relationship.

## Due medical care

Although there is no due medical care requirement, and no rules requiring a particular technique, most deaths occur using a technique developed in the Netherlands: a general anaesthetic is given intravenously to induce unconsciousness, after which, if necessary, a muscle relaxant is given which induces respiratory arrest. This approach accounted for 98 per cent of all reported cases in 2008/09 and 96 per cent of all reported cases in 2006/07, a proportion which has increased from 89 per cent in 2004/05, presumably as a result of better information availability on euthanasia methods.[224] Cases of euthanasia involving the use of opioids are often not labelled as euthanasia by physicians and thus are not reported although they are required to be.[225]

Among the 13 instances of termination of life without request conducted by a general practitioner during the 2005/06 SENTI-MELC research for which there is interview data, opioids only were administered in seven cases (53.8 per cent), opioids and a benzodiazepine in five cases (38.5 per cent), and barbiturates only in one case (7.7 per cent).

### Reporting and scrutiny

Data from the 2007 death certificate study in Flanders provide a good picture of reporting practice and the differences between reported and unreported cases. The estimated rate of euthanasia was 1.9 per cent of all deaths (95% CI 1.6% to 2.3%) and the reporting rate was estimated at 52.8 per cent (95% CI 43.9% to 60.5%).[226] The low reporting rate appears to have a similar explanation to the Netherlands (although the Dutch rate is much higher). Physicians only report those cases they perceive to be euthanasia, while many more cases are labelled as euthanasia by researchers.[227] The reporting rate for cases that physicians perceived as euthanasia was 93.1 per cent. Cases were more likely not to be perceived as euthanasia when the shortening of life was less than one week (which may mean that it would not be possible to comply with the due care criteria if the physician performed what he labelled as euthanasia). Cases involving older patients were less likely to be reported and more likely to involve opioids. The researchers conclude that it is possible that 'physicians find that older patients' requests or suffering are not explicit enough to merit what is in their eyes real euthanasia by bolus injection'.[228] A lack of knowledge about the reporting obligation also appears to play a significant role in non-reporting in Belgium.[229]

Both the 2007 death certificate and 2005/06 SENTI-MELC studies cover only the Dutch-speaking region of Belgium (Flanders) and there is some low quality evidence in support of the proposition that euthanasia is reported less frequently in the French-speaking region: a prevalence survey by a Belgian consumer organisation (the reliability of which has been doubted)230 put the imbalance at only 62 per cent of cases (Dutch) to 38 per cent (French), which is consistent with the population ratio.231

In the 2005/06 SENTI-MELC study, of all of the patients who received euthanasia whose GP was interviewed (n = 9), the reporting rate was 55.6 per cent:

One physician who did not report gave as the reason that they had forgotten (case 6). Another said it was not a case of euthanasia but of terminal sedation with the intention of hastening death so did not have

to be reported (case 7). The GP in case 8 did not report the case for the same reason that they did not consult a second physician [procedure too burdensome and not useful]. The physician in case 9 did not report it because they mistakenly thought that according to the law they should have waited for another 15 days.[232]

## OREGON

### Type of assistance

Assisted dying in Oregon is limited to physician assisted suicide by prescription of lethal medication, the principal medications used to bring about death being secobarbital and pentobarbital. The supply of barbiturates is subject to federal regulation under §829(a) of the Controlled Substances Act, which restricts the power to prescribe Schedule II medications to physicians. The restricted availability of lethal medication may deter individuals from assisting the suicides of others outside the circumstances prescribed by the DWDA, although there are no data on suicide assistance in Oregon by non-physicians.

The Oregon Department of Human Services (ODHS) annual reports show that a significant number of individuals issued a prescription for lethal medication do not use it.[233] While there may be a number of reasons for this phenomenon, it is possible that placing responsibility for the final act on the individual rather than the physician serves to prevent individuals ending their lives prematurely. Indeed, it may be that the setting of a date with a physician for euthanasia constitutes a form of passive pressure to end life, insofar as individuals feel that they are unable to back out once a date has been set.

Since ODHS is responsible both for collecting data on physician assisted suicide, and reporting non-compliance to the Oregon Board of Medical Examiners, it is not known whether the restriction of assisted dying to physician assisted suicide has resulted in unmet demand for euthanasia, in particular among individuals unable to ingest lethal medication.[234] However, the possibility for physicians to engage in such conduct may be limited by the requirement that pharmacists also file a report with the Oregon Department of

Human Services on dispensing lethal medication,[235] although it is also possible that physicians practising covert euthanasia or assisted suicide use medications not covered by the reporting requirements.

### Condition and/or experience of suffering

According to data from the ODHS, of the 525 individuals who received physician assisted suicide between 1998 and 2010, 80.8 per cent had cancer, 8 per cent had amyotrophic lateral sclerosis (a form of motor neurone disease), 3.8 per cent had chronic lower respiratory disease, and 1.5 per cent had HIV/AIDS.[236] It is not known whether individuals other than the terminally ill are receiving suicide assistance or euthanasia in Oregon,[237] although the high enrolment in hospice care among individuals who receive physician assisted suicide (88.7 per cent) would suggest that this is not the case.[238] However, some individuals with an incurable and irreversible disease may be issued a prescription for lethal medication, opt not to use it, and live longer than six months. This may indicate 'limitations in prognostication' regarding terminal illness.[239] Indeed, some clinicians willing to prescribe lethal medication have expressed doubts about their ability to determine whether an individual has less than six months to live.[240]

### Request

#### Capacity

Since ODHS is responsible for both monitoring physician assisted suicide and reporting non-compliance with the law, it may be unlikely that any physician would report the prescription of lethal medication to an individual without capacity.[241] Therefore, it is not known whether all individuals who have received physician assisted suicide since 1998 had capacity at the time they made the request. However, it is possible that individuals who request physician assisted suicide possess an 'unusually strong desire to remain independent and in control', which may indicate a certain concomitancy between capacity and physician assisted suicide requests.[242] This may be supported by the reasons given by individuals for requesting physician assisted suicide in the ODHS data.

Very little research has been conducted seeking to establish whether individuals in Oregon have received physician assisted suicide notwithstanding a diagnosis of mental disorder. In one study from 2000, 20 per cent of individuals who made requests for physician assisted suicide exhibited symptoms of depression, although none were prescribed lethal medication.243 In 2005, there were alleged to be three cases where individuals with mental disorder were prescribed lethal medication, although in two of these cases the claims regarding the presence of mental disorder are likely to be unreliable, since the diagnoses appeared to rely on press reports and were refuted by the examining clinicians.244 A recent systematic review of the prevalence of depression in granted and refused requests for euthanasia and assisted suicide identified a single high quality study (cross sectional survey) that had been conducted in Oregon.245 Of the patients making a request for physician assisted suicide, 15/58 (26 per cent) met the criteria for depression, with 3/18 (17 per cent) being prescribed lethal medication.246 It is not known whether the depressive disorder influenced the judgment of the three individuals who received physician assisted suicide, and therefore whether the assistance was lawful under the DWDA.247 However, 'the majority of patients requesting physician assisted suicide did not rank depression as a motivating factor in their request'.248

### Voluntariness

There have been several referrals to the Oregon Board of Medical Examiners for non-compliance with the requirement that two witnesses attest that the request for physician assisted suicide is being made voluntarily. In 2001, a physician was referred for providing only one signature on the request form, although other witnesses were in attendance.[249] Five more referrals were made between 2002 and 2010.[250] In these cases it was not reported by ODHS whether other witnesses were present. It is not known whether non-compliance with the witnessing requirements is indicative of a lack of voluntariness.

### Information provision

No data exist to suggest that physicians are not providing patients with the statutorily mandated information that would allow them to make an 'informed decision'.

#### Written request

There are no data to suggest that any individual has been provided with physician assisted suicide in Oregon without first having executed a written request.

### Age

It is not known whether any individual under the age of 18 has received physician assisted suicide in Oregon.

### Consultation and referral

#### Consultation with another physician

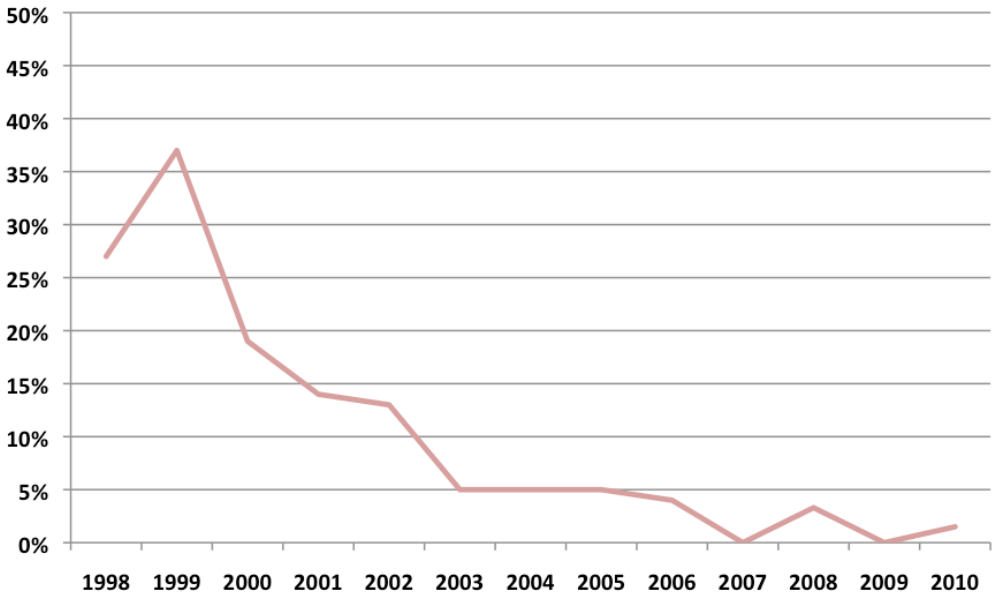
During the 13 years that physician assisted suicide has been lawful in Oregon, no physician has been referred to the Oregon Board of Medical Examiners for failing to refer an individual to a consulting physician.[251]

#### Counselling referral

There has been a downward trend in the number of individuals receiving physician assisted suicide who are referred to a mental health professional on the grounds of a suspected mental disorder impairing judgement (figure 2).[252] In 1998, the figure was 27 per cent, reaching a high of 37 per cent in 1999. The number in 2010 was 1.5 per cent. Other than a low quality study conducted in 2000, which found that none of 29 patients with symptoms of depressive disorder received a prescription for lethal medication,[253] it is not known how many patients are refused physician assisted suicide on the grounds of mental disorder. Such data might potentially explain the low number of psychiatric referrals for individuals ingesting lethal medication. It is also unknown whether physicians experience difficulty finding a mental health professional to whom they can refer the patient for counselling, although a survey conducted in 1999 found a large number of Oregon psychologists to be in favour of physician assisted suicide (91 per cent) and in favour of the DWDA (78 per cent).[254] The extent to which physicians systematically employ tools that enable the detection of mental disorder is also unknown.[255] However, if the prevalence of depression (17 per cent) in the small sample from the sole high

quality study is generalisable for the population of individuals receiving physician assisted suicide,[256] the mean percentage of individuals receiving psychiatric evaluation would appear to be considerably lower (7.5 per cent) than the number of individuals with mental disorder.[257]

Figure 2 Psychiatric referrals among individuals ingesting lethal medication under the DWDA in Oregon, 1998–2010




### Palliative filter

There are no data in Oregon on the rate of consultation with a palliative care team, or the number of referrals to palliative care, but it is known that of the 525 individuals who have died under the DWDA, 88.7 per cent have been enrolled in hospice care, which suggests that physician assisted suicide is not chosen as an alternative to palliative care.[258] However, in consideration of the diversity of participation in physician assisted suicide at hospices in Oregon, which ranges from 'nonparticipation or noncooperation',[259] to 'full participation within the parameters of the law',[260] it cannot be said with confidence that 'all patient care issues are resolved' before physician assisted suicide takes place, since information on hospice participation is only disclosed on enrolment.[261] Therefore, it may be that individuals have to circumvent hospice protocol in order to make arrangements for physician assisted suicide, or forego hospice care in order to receive physician assisted suicide.[262]

## Assistor

### Identity of assistor

ODHS monitors only physician assisted suicide under the DWDA. No prevalence data exist for Oregon, therefore, it is not known whether other individuals or organisations in Oregon are unlawfully assisting in the deaths of others.

### Physician patient relationship

Commentators opposed to the Oregon law have raised the possibility that a patient refused physician assisted suicide by one physician on the grounds of failing to meet one of the statutory criteria may obtain the prescription from a more accommodating physician.[263] Over the first three years of operation of the Oregon law, only 41 per cent of patients received their prescription from the first physician asked.[264] This suggests that in many cases there was no longstanding or pre-existing physician–patient relationship.[265] The median duration of that relationship in Oregon from 1998 to 2010 was ten weeks (range 0–1,905 weeks).[266]

### Nonparticipation in physician assisted suicide

In the first year of the DWDA (1998), it was reported that many hospitals and physicians were unwilling to participate in physician assisted suicide.267 Federally funded hospitals are prohibited from participating in it,268 and one quarter of 55 surveyed hospices in Oregon do not participate in physician assisted suicide at all.269 In 1998 and 1999, individuals seeking physician assisted suicide received prescriptions from the first physician approached in 53 per cent and 31 per cent of cases respectively. In 2000, this figure was 44 per cent.270 No data are provided after 2000, therefore it is unknown whether individuals seeking physician assisted suicide continue to experience difficulty in obtaining a prescription for lethal medication from the first physician they approach. In 2010, 59 physicians wrote 95 prescriptions

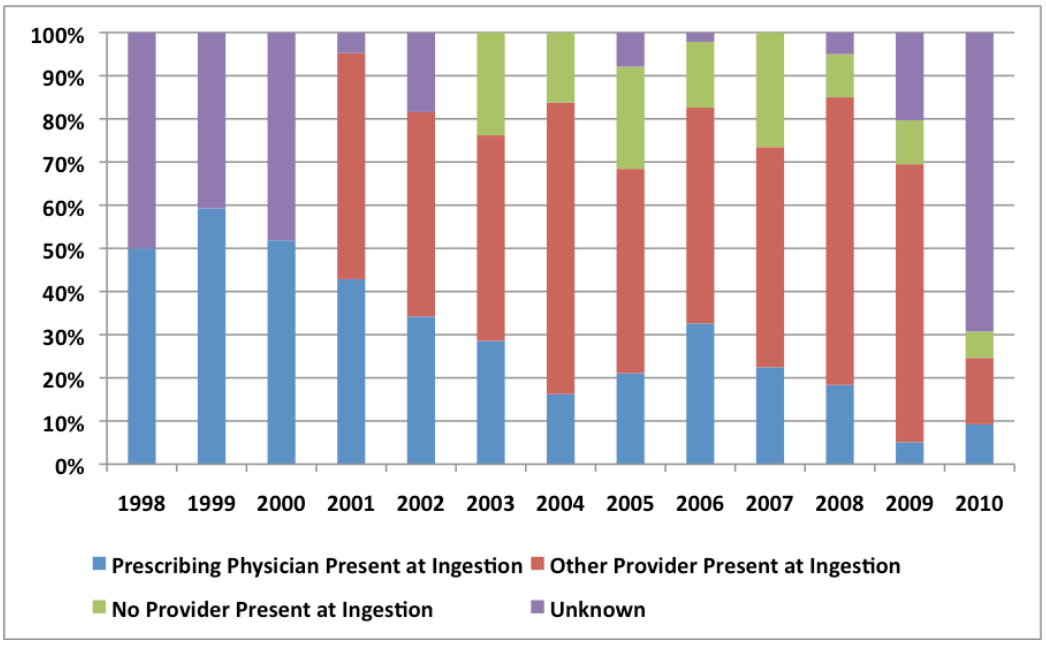
(range 1–11),[271] whereas in 2009, 55 physicians wrote 95 prescriptions (range 1–6).[272] These figures, which are representative of the experience of previous years, suggest that a relatively diverse number of physicians are writing prescriptions for lethal medication in Oregon. However, in 2010, one physician wrote 11 prescriptions,[273] and in 2007, one physician wrote ten prescriptions.[274] It is not known why these physicians were

responsible for over 10 per cent of prescriptions issued in these years, although it is possible that this is attributable to referrals from patient advocacy organisations such as Compassion and Choices of Oregon.

### Due medical care

For individuals who have died under the DWDA, the presence of the physician who provided the prescription of lethal medication at the moment of ingestion appears to have decreased from 1998 to 2010 (figure 3). ODHS revised its reporting procedure in 2010. Since 2010, data relating to healthcare providers present at ingestion are only collected when the prescribing physician or another health care provider is present at the time of death.[275] This resulted in unknown data for 45/65 (69.2 per cent) of the individuals who received physician assisted suicide in 2010, and inflated the figure for prescribing physician presence at ingestion (6/20, 30 per cent). The adjusted figure for physician presence, assuming that the prescribing physician or another health care provider present at the time death would have reported the prescribing physician's presence at ingestion, is 6/65 (9.2 per cent). Since 2001, ODHS has collected data on the presence of other health care providers at ingestion. These providers, who are often affiliated with Compassion and Choices of Oregon,[276] have attended the moment of ingestion in 43.4 per cent of cases (228/525, including 66 unknowns).

Figure 3 Physician or other health care provider presence at ingestion of lethal medication under DWDA in Oregon, 1998–2010[277]

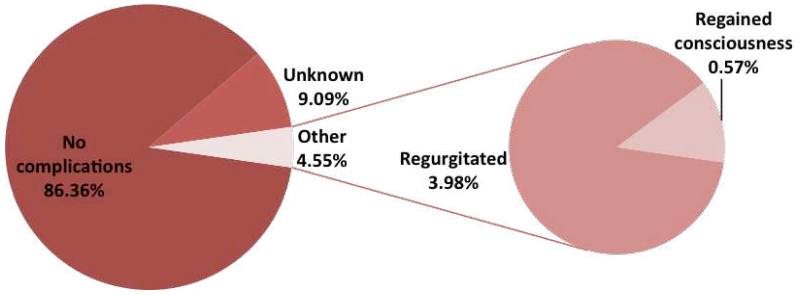



In 1998 and 1998, the prescribing physician was present at the time of death in 37.5 per cent and 48 per cent of DWDA cases respectively.[278] In 2009 and 2010, the prescribing physician was present at the time of death in 1.7 per cent and 9.2 per cent of cases respectively, with another health care provider present 79.7 per cent and 29.2 per cent of the time respectively.[279] In 2010, no provider was present at the time of death 60 per cent of the time.[280] In 2009 and 2010, ODHS reported averages for physician, other provider and no provider presence at time of death,[281] although since these figures were not included in the reports from previous years, their provenance is uncertain.

Since the DWDA prohibits any third party conduct that would accelerate the death of an individual who has ingested lethal medication,[282] the presence of the prescribing physician or other healthcare provider may not seem to be of great importance. However, it may be desirable to have a healthcare provider present (or at least in the vicinity) in the event of complications (see the next paragraph). Moreover, the absence of healthcare providers, in particular, the prescribing physician, may leave the individual who dies feeling abandoned 'by the very people who have assumed a fiduciary commitment to them in their terminal phase of life'.[283]

Complications are rare for individuals ingesting lethal medication in Oregon (figure 4). Between 1998 and 2010, 21 (4 per cent) individuals regurgitated the lethal medication, dying some time later without regaining consciousness, and three (0.6 per cent) individuals regained consciousness, dying sometime later from their underlying condition.[284] The median number of minutes between ingestion and unconsciousness was five minutes (range 1–38 minutes), and the median time between ingestion and death was 25 minutes (range 1 minutes to 104 hours).[285] ODHS revised its reporting procedure in 2010, the result of which is that information about time of and circumstances surrounding death is only included if the prescribing physician or another healthcare provider is present at the time of death.[286] This resulted in 37 cases where the number of complications was unknown in 2010, whereas there had been only 11 between 1998 and 2009. There were 33 cases where the time between ingestion and unconsciousness was unknown for 2010, and 38 between 1998 and 2009. There were 33 cases where the time between ingestion and death was unknown for 2010 and 33 between 1998 and 2009.[287]

Figure 4 Complications among individuals ingesting lethal medication under the Oregon Death with Dignity Act, 1998–2010



### Reporting and scrutiny

ODHS is required to collect data on patients and physicians who participate in physician assisted suicide under the DWDA, and to report physician non-compliance to the Oregon Board of Medical Examiners. The risk of referral to the Board of Medical Examiners renders it extremely difficult for ODHS to collect data on conduct that falls outside the DWDA, a point conceded in the first report.[288] No attempt has been made by ODHS, or any independent researchers, to document unlawful suicide assistance or euthanasia in Oregon since the entry into force of the DWDA, although a survey conducted in 1998 found that 3.7 per cent of oncologists practising in the USA had performed euthanasia during their career, and 10.8 per cent had assisted suicide during their career.[289]

A total of 22 physicians were referred to the Board of Medical Examiners between 1998 and 2010 for non-compliance with the provisions of the DWDA.[290] Non-compliance with the DWDA identified by the ODHS has been almost exclusively of a clerical nature, the most common items being incomplete or late physician reporting forms, or incomplete witness forms (missing signatures). However, in 2010, one physician was referred for failing to wait 48 hours between receipt of the patient's written request and writing the prescription.[291] It is not known whether non-compliance had any consequences for the physicians who were referred, although in 2007 and 2009, the Board of Medical Examiners found no violations of 'good faith compliance' with the DWDA, and thus 'did not sanction any [of the 12] physician[s] for 'unprofessional conduct'.[292] In 2005, one physician was referred to the Board of Pharmacy after an individual regained consciousness 65 hours after ingesting lethal medication.[293]

The data provided in the annual reports in Oregon appear to have declined significantly in quality between 1998 and 2010. While the Oregon Department of Human Resources had stated in its first report that subsequent reports were likely not to contain the level of detail provided in the first study,[294] the reports from 2007 onwards provide considerably less detail than those in previous years.[295] Moreover, data on variables that would have been useful in order to evaluate the implementation of the DWDA have ceased to be

collected, for example, whether individuals received a prescription from the first physician they approached, or the amount of barbiturate prescribed. Furthermore, some variables were not tracked from the entry into force of the DWDA, for example, the presence of another healthcare provider at ingestion or at time of death. The procedure revisions that occurred in 2010, which require the attending physician or another health care provider to be present at death in order for data to be collected on provider presence at ingestion, and time and circumstances at death, cast doubt on the reliability of data collected under the previous reporting procedure, since the provenance of data that would now be classified 'Unknown' is now uncertain.

## SWITZERLAND

### Type of assistance

It is not known how many prosecutions have been brought in Switzerland for assisting a suicide while acting from 'selfish motives'. However, the successful conviction in 2007 of a psychiatrist under article 115 of the Swiss Penal Code may suggest that the Swiss authorities are willing to prosecute 'selfishly motivated' individuals,[296] even though in this instance the conviction was quashed on appeal, since the motivating factor – a desire for publicity – was held not to fall within the scope of the criminal provision.[297]

The 2001/02 EURELD Consortium study suggests that physician administered euthanasia (termination of life on request), although illegal, accounted for a small number of deaths in Switzerland (0.27 per cent (95% CI 0.14% to 0.51%)).[298] Physician termination of life without explicit request accounted for 0.42 per cent of deaths (95% CI 0.25% to 0.70%).[299] It has been noted that 'apart from rare cases of serial offences, convictions are extremely rare'.[300] One conviction in 2004 involved 24 killings and three attempts to kill,[301] and another involved an employee of a right to die organisation who accelerated the deaths of two unconscious individuals who had ingested barbiturates.[302] The low rate of convictions may be explained by prosecutorial unwillingness to bring all but the most

egregious cases to trial.[303] Prosecutorial reluctance to try euthanasia cases may also be explained by the risk of establishing a jurisprudential rule whereby euthanasia would be permissible under the defence of necessity. Such a rule may have been established in December 2010.[304] It is not known whether non-medically trained individuals are unlawfully engaging in euthanasia in Switzerland, although the number of lay individuals assisting in the suicides of others would appear to be very low, 'or at least the authorities are hardly ever aware of such cases, nor has there been any research on the subject'.[305]

### Condition and/or experience of suffering

Data from the right to die organisation EDS, which operates across Switzerland, for 331 cases from 1990 to 2000, found that 21 per cent of the individuals who received suicide assistance 'had no apparent fatal medical condition',306 of which 2.7 per cent had depression or schizophrenia. A study of 43 consecutive suicides assisted by EDS between 1992 and 1997 in the Basel region found 'no severely disabling or terminal illness' in 26 per cent of cases, and 14 per cent of individuals to have received treatment in a public psychiatric institution.[307] A study for the period 2001–2004 of all suicides assisted by EDS and Dignitas that were investigated by the Institute of Legal Medicine in Zurich (n=421) found that non-fatal diseases accounted for 32 per cent of EDS deaths (47/147) and 21.2 per cent of Dignitas deaths (58/274).[308] Mental disorder accounted for 2 per cent and 3.3 per cent of assisted suicides respectively.[309]

It is not known whether any prosecutions have been brought against clinicians who prescribed lethal medication to individuals with non-fatal conditions, notwithstanding that this may be contrary to accepted medical practice.[310] There is some evidence of prosecutions of physicians who assisted the suicides of individuals with mental disorder during the aforementioned study periods, when such assistance was judged not to be accepted practice.[311] However, in the two later cases, the primary factor in favour of prosecution may not have been the condition of mental disorder, but the physicians' lack of due care in their dealings with the individual(s) concerned.[312]

The presence of depression is relevant to the question whether the patient's suffering has no prospect of improvement. Between 1997 and 2000, among 90 eligible suicides assisted by EDS (total EDS assisted suicides = 166), 24 individuals (27 per cent) were found to have depression.313 The prevalence of depression among refused requests at EDS during the same period is not known. In a 12-month study of requests for assistance to die in six palliative care facilities (which have no policy of suicide assistance), 14/39 patients (36 per cent) of individuals who made a request either for euthanasia (64 per cent) or assisted suicide (36 per cent) had depression, though this was severe only in 1/39 (2.6 per cent) of the cases.314 After one month, 3/39 (7.7 per cent) persisted in their wish to die; 16/39 (41 per cent) no longer expressed the wish without this being attributable to symptom relief; 16/39 (41 per cent) had died before it was possible to verify whether or not the wish persisted; and data were unavailable for 4/39 (10.2 per cent).[315] At six months, 26/39 (67 per cent) patients had died from their underlying condition, and 2/39 (5 per cent) had committed suicide at home (it is not known whether this was done with assistance).[316]

Somewhat analogous to the Dutch 'no prospect of improvement' criterion, since 2006, mentally disordered individuals are required to demonstrate that 'the wish to die [is] a product of a reasoned and settled decision of an individual with capacity' – not the result of a treatable mental disorder.[317] This necessitates 'expert medical opinion, in particular an extensive psychiatric evaluation'.[318] It is not known whether any mentally disordered individuals have received a prescription for sodium pentobarbital since 2006, although in consideration of the onerous nature of the procedure, it is likely that very few individuals with mental disorder will be prescribed lethal medication.

### Request

#### Capacity

The Swiss authorities have brought prosecutions where an individual has been prescribed lethal medication notwithstanding doubts in respect of mental capacity.[319] However, the cited cases have involved individuals with mental disorder, and physicians who

have failed to act with due care. It is not known how many individuals not suffering from mental disorder are refused suicide assistance for lack of capacity. Nor is it known whether individuals who are suspected to lack capacity are referred systematically to a mental health professional for further evaluation, either by their physicians or a right to die association, although this may be practice in acute care hospitals.[320] However, it has been noted that the right to die organisations receive 'many more requests for assisted suicide than actual assistance'.[321]

The presence of depression is relevant to the question whether the patient is competent. Unfortunately there is no evidence of the prevalence of depression in granted or ungranted requests for assisted suicide in Switzerland, since for the two studies examining the prevalence of depression (see 'Condition and/or experience of suffering', above), one has concerned only granted requests (for which the individual must have had capacity in order for the suicide to be lawful),[322] and the other involved institutions that have no policy of assisting suicides.[323]

### Age

There are no data to suggest that any individual who would not be presumed to have capacity under Swiss Civil Law has received suicide assistance; nor is it known whether any minors with capacity have received a prescription for lethal medication.

### Consultation and referral

There appears to be no practice in Switzerland of consulting another physician on whether a patient meets the criteria for assisted suicide. However, for individuals assisted by a right to die association, or residing in an acute care hospital, there may be system of consultation involving a physician and another individual who is not necessarily medically trained.

It is not known whether individuals who contact the Swiss right to die organisations are referred systematically to mental health professionals in order to detect the presence of mental disorder, verify capacity or for counselling. EDS volunteers are trained in counselling, and may refer individuals not meeting the criteria for assisted suicide to counselling.[324] In acute care hospitals, a

psychiatric assessment may be provided if indicated.[325] Should 'treatment adaptation' be possible, this would appear to rule out the possibility of assisted suicide, although it is not clear whether a refusal of treatment will also rule out assisted suicide.[326]

### Assistor

Between 1997 and 2000, for 166 suicides assisted by EDS in the Zurich canton, 31 per cent of individuals received a prescription of sodium pentobarbital from their attending or family physician, and 51 per cent received a prescription from a physician affiliated with EDS.[327] For the same period, the medical report or opinion was issued in 79 per cent of cases by the attending or family physician, with only 13 per cent of EDS physicians fulfilling this role.[328] Between 2001 and 2004, for 147 EDS assisted suicides in the Zurich canton, 61.9 per cent of individuals received sodium pentobarbital from their attending physician or family physician, compared with 35.4 per cent who received a prescription from an EDS-affiliated physician.[329] For 274 Dignitas assisted suicides during the same period and in the same region, 93.4 per cent of individuals received a prescription from a Dignitas affiliated physician, with only 6.6 per cent receiving lethal medication from an attending or family physician.[330]

The figures for EDS suggest that some individuals may have difficulty securing lethal medication from their family or attending physician, although it may be less difficult to secure such medication than previously (at least in the Zurich canton). Few individuals (8.8 per cent) who received suicide assistance at Dignitas were resident in Switzerland, the majority originating from Germany, the UK and France.[331] Therefore, the Dignitas figures do not indicate that Swiss residents have difficulty securing lethal medication from their attending or family physicians. In fact, if it is assumed that only Swiss residents received a prescription from an attending or family physician, the percentage of individuals who received such a prescription from a Dignitas affiliated physician (25 per cent) is lower than that of EDS (35.4 per cent).

### Due medical care

Physicians who depart from accepted professional and scientific practice in prescribing lethal medication to individuals wishing to

commit suicide may lose the authorisation to prescribe controlled substances,[332]or potentially be convicted for negligent homicide.[333]

'No serious complications or cases of reawakening from coma' were reported among suicides at EDS in Switzerland between 1990 and 2000.[334] This may be because of nausea and vomiting prevention measures taken before administration.[335] In the 300 suicides that occurred at EDS in the Zurich canton, 276 (92 per cent) resulted from oral ingestion of barbiturates.[336] Intravenous infusion and PEG catheter as a means of administration of barbiturates became permissible in 1997,[337] and were used in 22 (7 per cent) and 2 (0.7 per cent) cases respectively.[338] Between 2001 and 2004, 24.5 per cent of EDS and 9.1 per cent of Dignitas suicides in the Zurich canton were by intravenous infusion or PEG. For the 1990–2000 sample, the median interval before death was 23 minutes (range 7–1,075 minutes) for sodium pentobarbital and 25 minutes (range 11–626 minutes) for secobarbital.[339] This compares with a median time of 16 minutes (range 4–45 minutes) for intravenous infusion of sodium pentobarbital.[340]

### Reporting and scrutiny

There is a significant amount of oversight of assisted suicide in Switzerland since 'each case of assisted death must be investigated by the police to determine if the suicide was in compliance with the law, [… if it is not] the matter is referred to the public prosecutor'.341 There is no evidence that right to die organisations fail to report deaths to police.342 Indeed, it has been noted that suicides reported by the right to die organisations match 'the results of an international study on medical end-of-life decisions based on anonymous reports by a large number of physicians attending dying patients'.343 The right to die organisations keep records of every suicide that they assist, and in the majority of cases these records, alongside the coroner's report and witness statements gathered by the police, '[succeed] in communicating the suffering which led to the wish to die'.344 However, EDS records for 61/147 suicides assisted in the city of Zurich between 1990 and 2000 did not contain a medical report, although it was possible for the Institute of Legal Medicine to establish the accuracy of the diagnostic group given by EDS in 57 of these cases. Moreover, the health status

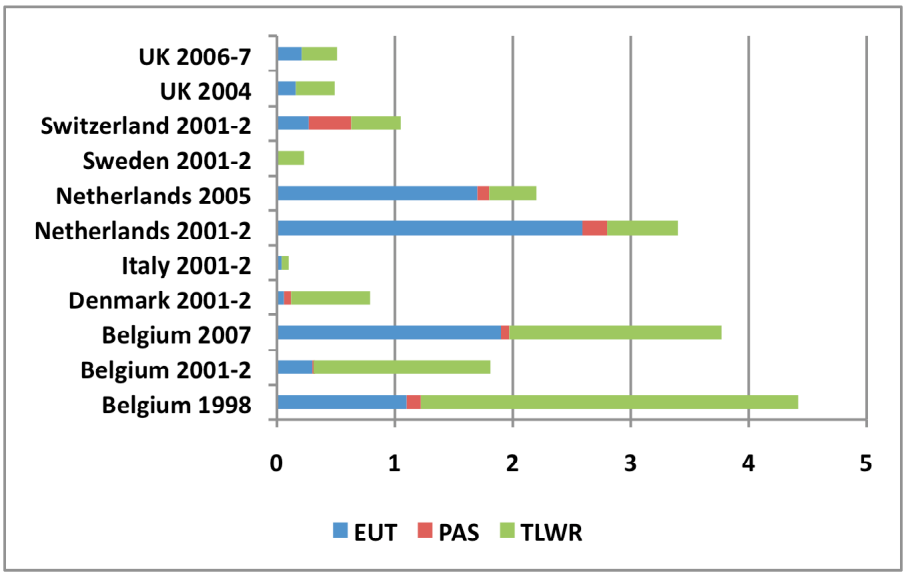
reports provided by physicians, which contribute to the decision of whether or not to provide sodium pentobarbital, contain varying amounts of detail, although it would appear that the minimum content is a list of medical diagnoses.345

# PART 3 ASSESSMENT OF SAFEGUARDS AND RECOMMENDATIONS

## Type of assistance

The lack of prevalence data in Oregon on either euthanasia or termination of life on request does not permit any conclusions to be drawn about the effectiveness of restricting the type of assistance to only physician assisted suicide. Comparative data across Europe are found in figure 5, which shows the percentage of all deaths in specific years that were cases of euthanasia, physician assisted suicide, or termination of life without request. It combines data from a number of different anonymous prevalence surveys of doctors.[346] The data reveal that termination of life without request (the data for which in the Netherlands, Belgium and Switzerland has already been mentioned) is prevalent in both permissive and prohibitive jurisdictions. Switzerland is the only jurisdiction in which the rate of assisted suicide is greater than the rate of euthanasia, which may indicate a successful attempt to permit only assisted suicide but not euthanasia.

Figure 5 Rates of euthanasia, physician assisted suicide and termination of life without request in some European countries, 1998–2006/07




There are no robust data on the effectiveness of the unselfish motive criterion in Switzerland, although prosecutions in this regard suggest that the criterion is applied to some extent. The way in

which this criterion has been narrowly interpreted in a recent case may limit its effectiveness.

### Condition and/or experience of suffering

There is no evidence from Oregon that individuals who have not been diagnosed with a terminal illness are receiving physician assisted suicide. The unbearable suffering criterion is used by attending and consulting physicians in the Netherlands and Belgium to weed out a significant proportion of requests. Reported cases in both of those jurisdictions almost all meet the criterion when examined by the relevant reviewing body.

The presence of depression is relevant to the question whether the patient's suffering has no prospect of improvement (in the Netherlands and Belgium), although not determinative of this question, since the short life expectancy of some potential patients seeking assisted dying may limit the potential for full remission of clinical depression.[347] (In such cases, provided that the individual retains capacity, the authors of the systematic review conclude that 'it is possible for euthanasia/PAS [physician assisted suicide] to be a valid choice despite the presence of depression'.[348]) In the Netherlands, depression is significantly less prevalent in granted requests than in refused requests, and severe depression is not significantly present in requests generally.

In Switzerland, where the terminal illness criterion appears only in the non-binding SAMS guidance, those who obtain assisted suicide exhibit a wider range of conditions and levels of suffering, including existential suffering (tired of life cases). This may be because the right to die organisations do not regard the guidance as a constraint on their activites. The Swiss courts have imposed an additional requirement on individuals whose primary condition is non-somatic (mental illness or disorder). Their request must not be the result of a treatable mental disorder. Although no sufficiently recent Swiss data exist, the stringency of the procedure has significantly reduced the already slim chance that any individual with a mental disorder will be prescribed lethal medication.

Both unbearable suffering and terminal illness appear to be well adhered to when they are legally binding. While the evidence does

not suggest that one criterion should be preferred over the other, the Swiss experience does support the imposition of one of these criteria over a more relaxed regime that potentially fosters legal and medical uncertainty.

### Request

#### Capacity

The capacity criterion is used by attending and consulting physicians in the Netherlands and Belgium to weed out a significant proportion of requests. The relevant reviewing body determined that the capacity criterion was met in all recent reported cases in both of those jurisdictions. In Switzerland, prosecutions have occurred in cases where there have been doubts over the individual's capacity, although all of these prosecutions have involved mentally disordered individuals and (as in Oregon) there is no evidence of refusals on the grounds of incapacity in individuals suffering from somatic illnesses. As a safeguard, the capacity criterion appears to be effective in ensuring that incompetent individuals do not receive assisted dying.

Considerable disagreement exists over the prevalence of mental disorder in individuals who request physician assisted suicide, and the influence that mental disorder may have on capacity to request assisted dying.[349] This disagreement may be exacerbated by the fact that 'competence itself is a complex concept, determinations of decision-making capacity are not clear-cut, and the relationship between mental illness and decision-making capacity in dying patients is not clearly understood'.[350] Moreover, there is a risk that the assessments of mental health professionals who are asked to assess the capacity of individuals requesting physician assisted suicide will be influenced by their own moral and ethical views.[351] In both the Netherlands and Oregon, depression is significantly less prevalent in granted requests than in refused requests, and in the Netherlands, severe depression is not significantly present in requests generally. The evidence would appear to suggest that individuals with depression who receive assisted dying nevertheless retain capacity to make a request.

#### Voluntariness

The voluntariness criterion is used by attending and consulting physicians in the Netherlands and Belgium to weed out a small proportion of requests. Recent reported cases in both of those jurisdictions all met the voluntariness criterion when examined by the relevant reviewing body. In Oregon, by contrast, some cases have raised voluntariness concerns as a result of failures to meet the witnessing requirements designed to ensure voluntariness; however it is not known whether non-compliance with the witnessing requirements is indicative of a lack of voluntariness. We have not found any data on whether voluntariness is more problematic in unreported cases. Although the evidence is not overwhelming, it may be the case that discussions between the patient and more than one physician (as required in the Netherlands, Belgium and Oregon) are more effective at screening out voluntariness problems than simply requiring multiple witnesses to a written request (as in Oregon).

### Information provision

There is too little evidence on the effectiveness of this safeguard to draw conclusions, but the one small Belgian study which looked at this found that the requirement was met in 100 per cent of euthanasia cases.

### Written request

This requirement appears to be well respected where it exists. The Dutch experience indicates that in rare cases it may be difficult to fulfil, so there may be grounds for allowing narrow, principled exceptions to a general rule. The requirement for a written request has particular instrumental value as an aid to retrospective scrutiny of reported cases.

### Age

Restrictions on the basis of age appear to be well observed in all of the jurisdictions studied although the evidence base is limited. A more principled approach could be to base decisions on capacity rather than age.

### Consultation and referral

A number of additional functions may be served by a consultation requirement, including quality control, avoidance of idiosyncratic

judgments, provision of information to the attending physician, and enabling effective retrospective scrutiny of actions and decisions.[352]

### Consultation with another physician

In the Netherlands, Belgium and Oregon, the consultation requirement(s) are met in virtually all reported cases. The rate is much lower in unreported cases in the Netherlands and Belgium; no corresponding data exist for Oregon. (This is probably primarily due to the labelling phenomenon discussed below in the context of reporting.)

We recommend the adoption of a requirement for independent consultation. Such a requirement appears effective at screening out a significant proportion of cases which do not meet the substantive criteria (approximately 25 per cent of SCEN cases in the Netherlands and 23 per cent of all cases in Belgium, for example). Although no data exist for the proportion of cases in Oregon which are screened out by consultants, the lack of an independence requirement in Oregon might suggest that the proportion is lower. Independence of the consultant is required and almost always present in the Netherlands and Belgium. Although not required by any regime, specially trained consultants may improve the quality of consultations. Attending physicians appear to have welcomed the availability of such specially trained consultants via the SCEN and LEIF networks.

### Discussion with nursing team

Belgium is the only jurisdiction that specifically requires discussion with the nursing team, and the requirement is not well adhered to. There is no evidence which would tell us whether such discussion aids in screening out those who do not meet the substantive criteria.

### Counselling referral

Oregon is the only jurisdiction that requires counselling if an accompanying mental illness or disorder that impairs judgment is suspected. This requirement is substantive as well as procedural since the request cannot proceed unless the counsellor determines that the mental illness or disorder does not impair judgment. There are no data on the number of cases in which the counsellor determines that the mental illness or disorder does impair judgment, or even on the number of counselling referrals in those

who do not receive physician assisted suicide. There is a downward trend in the number of counselling referrals in those who do ultimately receive physician assisted suicide, and the (limited) data on the presence of depression in this population suggest that counselling referrals are not taking place as often as the statute requires. To be effective, such a requirement might need to be coupled with the routine use of validated screening tools by the attending physician.

#### Palliative filter

A palliative filter operates *de facto* in some institutions in Belgium and is used by some organisations in Oregon[353] and Switzerland.[354] The absence of a legal requirement makes it difficult to evaluate its effectiveness, although there is evidence of consultations with palliative care teams in the reported cases in Belgium.

### Assistor

#### Involvement of nurses

Since the only assistance provided in Oregon and Switzerland is the provision of a prescription, there is no evidence of nurses' involvement. In the Netherlands and Belgium, nurses are involved in the administration of euthanatica, although more in unreported than in reported cases (at least in Belgium), and the unreported cases are likely those not labelled as euthanasia by the attending physician. The labelling phenomenon is discussed below in the context of reporting.

One Dutch study recommended the use of '[m]ultidisciplinary institutional guidelines' to improve collaboration between physicians and nurses and prevent the involvement of nurses in the administration of euthanatica, which 'contrasts sharply with the legal rules and the professional responsibilities of nurses'.'[355] The same study recognised that such multidisciplinary guidelines might not work in the homecare sector in the Netherlands, as a result of the way it is structured, but advocated the use of guidelines specifically for nurses in which 'their role and responsibilities are clearly described'.[356] Studies of nurses' involvement in Belgium have made similar recommendations in favour of guidelines.[357] Better training of nurses and physicians in relation to their roles and responsibilities in end of life decision-making might also help

to prevent unlawful behaviour. It is likely though that the most significant contribution to this problem would be to address the labelling phenomenon (see 'Reporting and scrutiny', below).

### Relationship with patient and conscientious objection

There are no formal requirements for a physician–patient relationship of a particular length or quality. The limited data do not show whether patients who had only a brief relationship with their physician obtained assisted dying despite not meeting one or more criteria. In the Netherlands, the regional review committees have identified a few cases where the physician's treatment relationship with the patient was not sufficient to allow for proper assessment of the patient's request and/or suffering. The remaining data only deal with the brevity of the relationship and not with the physician's ability to assess whether the patient met the criteria. In the first three years of the DWDA in Oregon, a large number of individuals seeking a prescription for physician assisted suicide had to approach more than one physician; no data exist beyond this period. In Switzerland, in approximately a quarter to a third of cases, Swiss residents secure a prescription from a physician affiliated to a right to die organisation with whom they have no pre-existing relationship.

One might hypothesise that the more substantial the relationship between physician and patient, the easier it is for the physician to assess whether the substantive requirements are met,[358] and the more likely that assessment is to stand up to prospective (by a consultant) and retrospective scrutiny. In the presence of conscientious objection, the patient may not be able to establish a sufficiently substantial relationship with a new physician, particularly in cases involving terminal illness. No robust comparative data exist to support this hypothesis.

### Due medical care

The due medical care requirement in the Netherlands is generally well adhered to in reported cases with the small number of problems subject to scrutiny by the regional review committees and often referral to prosecutors and regulators. There is no evidence that there are more problems in this regard in unreported than reported cases (although this data are not recent).[359]

In Oregon, the fact that all complications (with the possible exception of one individual who regained consciousness) related to regurgitation raise the question whether oral ingestion is the best means for individuals to bring about the end of their lives, since vomiting may occur even where an anti-emetic agent is prescribed.360 Moreover, the fact that some patients may remain alive for a considerable period of time after becoming unconscious may cast doubt on whether fast acting barbiturates are the lethal substance best adapted to physician assisted suicide, particularly since the DWDA prohibits any action to accelerate the death of the individual who has ingested the medication. It may be that there are other means of administration that are less likely to result in complications, which also leave no doubt as to the voluntariness of the conduct bringing about death. It is also possible that there are lethal medications better adapted to bringing about a rapid and peaceful death for individuals than those currently used.

These issues which have arisen in Oregon regarding regurgitation and regaining of consciousness suggest that there may be problems with the limited means of delivery allowed by the DWDA, the failure to include a requirement that a physician be present, and the impermissibility of euthanasia in response to problems with an assisted suicide, although concomitant benefits need also to be considered, including the risk to voluntariness associated with physician presence and euthanasia (versus assisted suicide). The Swiss experience suggests that the use of parenteral means of administration may prevent some of the problems that have occurred in Oregon (provided that it is only the final act on which the lawfulness of suicide assistance is contingent). The use of parenteral means may also obviate the potential for euthanasia in the event that an individual 'lingers on'.

### Reporting and scrutiny

There are no data on the reporting rate in Oregon. The reporting rate within the right to die organisations in Switzerland may be 100 per cent. In the Netherlands and Belgium, the reporting rate is rising and is significantly higher (80 per cent) in the Netherlands than in Belgium (53 per cent), where legalisation occurred more recently.

The rate in the Netherlands rose when the regional review committees were inserted as a buffer between physicians and the authorities. The Swiss experience suggests that a buffer may not be needed to encourage reporting if the process leading up to the assistance involves several layers of administration coupled with few legal requirements.

The primary reason for not reporting in the Netherlands and Belgium appears to be a difference in labelling between physicians and researchers. Well over 90 per cent of cases labelled as euthanasia by physicians in both jurisdictions are reported. This suggests that the most important factor in raising the reporting rate is the education of physicians in the identification and correct labelling of cases that meet the definition of euthanasia. Physicians need more clarity on when to report.[361] The Belgian data also suggest that some physicians fail to report because they are unaware of the reporting obligation, indicating a need for an education programme when rolling out a new reporting regime.

The regimes in the Netherlands, Belgium and Oregon all require the referral of cases that do not meet the statutory criteria to either the prosecutorial authorities, or the professional disciplinary authorities, or both. In the Netherlands, 0.21 per cent of reported cases were referred the prosecutorial authorities by the regional review committees between 1999 and 2009. No prosecutions have been brought following these referrals.[362] In Belgium, no cases have been reported to the prosecutorial authorities by the CFCE. If, hypothetically, a similar referral rate to the Netherlands were expected, then one would expect approximately seven referrals relating to cases that were reported between 2002 and 2009.[363] (Of course there may be good reasons why the referral rate in Belgium would be different from the Dutch rate.) There is no evidence that the CFCE is not referring cases that should have been referred. A study of all reported cases from 2002 to 2007 concluded that the request and consultation requirements were met in all cases.[364] An alternative explanation for the lack of referrals may be that Belgian doctors do not report cases unless they meet all of the legal requirements. This theory is supported by one small qualitative study.[365]

In Oregon, the number of physicians referred to the Orgeon Board of Medical Examiners for non-compliance with the DWDA as a percentage of the number of DWDA deaths between 1998 and 2010 is 4.2 per cent (22/525), which suggests that ODHS operates a robust policy of referral in cases of non-compliance.[366] This may be supported by the fact that ODHS referred a physician to the Board of Pharmacy in one of the three cases where an individual regained consciousness after ingesting medication – an act that may not be within its competence. Moreover, in consideration of the principally clerical nature of non-compliance with the DWDA, it is perhaps unsurprising that the Board of Medical Examiners has not, to our knowledge, to date sanctioned a single physician.

What does a referral rate tell us about the effectiveness of a reporting requirement? To evaluate whether the referral rate in a particular jurisduction is too low, we would need a detailed examination of all of the reported cases, identifying any that should have been referred but were not. Unfortunately no such data exist. Low referral rates are to be expected, either because of high rates of adherence to the rules (eg. in the Netherlands), or in other jurisdictions because non-reporting is likely in cases that do not meet the statutory criteria. Nevertheless, in order to foster compliance with the regulatory regime, it is essential that bodies charged with referral do in fact exercise this power in appropriate cases.

## NOTES

1 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001, s.2(1)(b).
2 Ibid, s.2(1)(d).
3 Law on Euthanasia of 28 May 2002, s.3(1).
4 Ibid, s.3(3).
5 Oregon Death With Dignity Act, Oregon Revised Statutes §§127.800-127.995 (1999), §1.01(12).
6 Verwaltungsgericht des Kantons Zürich, Entscheid der 3 Kammer VB Nr 9900145 (1999) (Zurich Case).
7 *Haas*, Schweizerisches Bundesgericht, Entscheid 2A48/2006, 2006, 3 Nov 2006.
8 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001, s.2(1)(a).
9 Law on Euthanasia of 28 May 2002, ss.3(1), 3(2)(1).
10 Oregon Revised Statutes 127.800-127.995, §1.01(7).
11 Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001, s.2(3).
12 Law on Euthanasia of 28 May 2002, s.3(3).
13 See for example *van Oijen*, Supreme Court, 9 Nov 2004, NJ 2005, no 217; *Vencken*, District Court, Breda, Nov 2004; *Den Bosch*, Court of Appeals, 29 Jul 2005.
14 Commission fédérale de contrôle et d'évaluation de l'euthanasie, *Premier rapport aux chambres legislatives* (2002–2003), 2004, pp 13–14.
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19 Average rate of 80.8 per cent using data from the four CFCE reports covering the period 2002–2009: CFCE, 1er rapport, 2002/03, pp 7–8; Commission fédérale de contrôle et d'évaluation de l'euthanasie, *Deuxième rapport aux chambres législatives (2004-2005)*, 2006, pp 15–16, 22; Commission fédérale de contrôle et d'évaluation de l'euthanasie, *Troisième rapport aux chambres législatives (2006-2007)*, 2008, p 16 (81 per cent); Commission fédérale de contrôle et d'évaluation de l'euthanasie, *Quatrième rapport aux chambres législatives (2008-2009)*, 2010, pp 16, 22 (79 per cent).
20 ODHS, *Thirteenth Annual Report on Oregon's Death with Dignity Act*, 2011, table 1.
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30 Ibid p 473.
31 Verwaltungsgericht des Kantons Zürich, *Entscheid der 3 Kammer VB Nr 9900145*, 1999, (Zurich Case).
32 SAMS Guidance 6.
33 *Haas*, Schweizerisches Bundesgericht, Entscheid 2A48/2006, 2006,3 Nov 2006, [6.3.5.1].
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63 See, for example, Regional Euthanasia Review Committees, *Jaarverslag 2009*, casi 15, 16; Regional Euthanasia Review Committees, *Jaarverslag 2008*, 2009, casi 12, 13.
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67 NVP, *Richtlijn omgaan met het verzoek om hulp bij zelfdoding door patiënten met een psychiatrische stoornis*, p 70. See also, Griffiths et al, *Euthanasia and Law in Europe*, p 101.
68 Regional Euthanasia Review Committees, *Jaarverslag 2005*, 2006, 32; Regional Euthanasia Review Committees, *Annual Report 2006*, 2007, p 33 ('In exceptional cases different arrangements may be made in advance, but only for good reasons. The physician must always be on hand to intervene quickly if the euthanatics do not have the desired effect. Euthanasia must always be performed by the physician himself.'); Regional Euthanasia Review Committees, *Jaarverslag 2007*, 2008, p 31.
69 Regional Euthanasia Review Committees, *Jaarverslag 2009*, p 38; Regional Euthanasia Review Committees, *Jaarverslag 2008*, p 29.
70 Griffiths et al, *Euthanasia and Law in Europe*, p 322.
71 Commission fédérale de contrôle et d'évaluation de l'euthanasie, *Brochure d'information déstinée aux médicins*, 6 Sep 2005, p 14.
72 ORS 127.800-127.995, §3.01(8), 3.09.
73 Bosshard, 'Switzerland' 472. Formerly secobarbital was used in a small number of cases: Bosshard et al, '748 cases of suicide assisted by a Swiss right-to-die organisation'.
74 Loi fédérale sur les stupéfiants, arts 9(1), 10, 11.
75 Ziegler and Bosshard, 'Role of non-governmental organisations in physician assisted suicide', p 296.
76 Bosshard, 'Switzerland', p 479.
77 Ogden et al, 'Assisted suicide by oxygen deprivation with helium at a Swiss right-to-die organisation'.
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79 Data compiled from: Regional Euthanasia Review Committees, *Jaarverslag 2009*, p 50; Regional Euthanasia Review Committees, *Jaarverslag 2008*, p 36; Regional Euthanasia Review Committees, *Jaarverslag 2007*, casi 5, 11, 12; Griffiths et al, *Euthanasia and Law in Europe*, pp 214–15.
80 ODHS, *Oregon's Death with Dignity Act: The second year's experience*, 2000; Oregon Department of Human Services, *Oregon's Death with Dignity Act: Three years of legalized physician-assisted suicide*, 2001; ODHS, *Fifth Annual Report on Oregon's Death with Dignity Act*, 2003; ODHS, *Sixth Annual Report on Oregon's Death with Dignity Act*, 2004; ODHS, *Seventh Annual Report on Oregon's Death with Dignity Act*, 2005; ODHS, *Eighth Annual Report on Oregon's Death with Dignity Act*, 2006; ODHS, *Twelfth Annual Report on Oregon's Death with Dignity Act*, 2010.
81 Bosshard et al, '748 cases of suicide assisted by a Swiss right-to-die organisation', p 311.
82 UN Human Rights Committee, *Concluding Observations of the Human Rights Committee: Switzerland* (CCPR/C/CHE/CO/3, 2009) para 13.
83 Federal Department of Justice and Police (Switzerland), 'Assisted suicide: strengthening the right of self-determination', 2011, www.admin.ch/aktuell/00089/index.html?lang=en&msg-id=39905 (accessed 6 Sep 2011).
84 Commissie Late Zwangerschapsafbreking en Levensbeëindiging bij Pasgeborenen, *Gecombineerd Jaarverslag over de jaren 2009 en 2010*, 2010, p 21.
85 AA Verhagen et al, '[Deliberate termination of life in newborns in The Netherlands; review of all 22 reported cases between 1997 and 2004]', *Ned Tijdschr Geneeskd* 149, 2005, p 183.
86 An examination of the national data reveals rates of termination of life without explicit request as follows: 0.8 per cent of all deaths in 1990 (95 per cent CI = 0.6–1.0), 0.7 per cent in 1995 (95 per cent CI = 0.5–0.9), 0.7 per cent in 2001 (95 per cent CI = 0.5–0.9) and 0.4 per cent in 2005 (95 per cent CI = 0.2–0.6). A van der Heide et al, 'End-of-life practices in the Netherlands under the Euthanasia Act', *New England Journal of Medicine* 356, 2007, p 1957, table 1.
87 A 2001 study of children found that 2.7 per cent (95 per cent confidence interval (CI) 1.2 per cent-6.1 per cent) of all reported deaths of children (aged 1 to 17) during the four-month period studied involved the use of drugs with the explicit intention of hastening death. AM Vrakking et al, 'Medical end-of-life decisions for children in the Netherlands', *Archives of Pediatrics & Adolescent Medicine* 159, 2005, p 802, 804, table 1. The decision was made at the child's request in 0.7 per cent of cases (95 per cent CI 0.1 per cent-3.6 per cent) (although this would not have been a legally valid request) and at the request of the family in 2 per cent of cases (95 per cent CI 0.8 per cent-5.2 per cent).
88 The evidence on the total number of cases involving neonates has remained consistent across the three national surveys in which data was collected. In 2005, 2001 and 1995, approximately 6-8 per cent of neonatal deaths studied involved decision to forgo life-sustaining treatment combined with drugs given explicitly to hasten death and 0–1 per cent of cases involved administration of drug explicitly to hasten death to an infant not preceded by a decision to withhold or withdraw life-sustaining treatment. B

Onwuteaka-Philipsen et al, *Evaluatie: Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding*, Den Haag: Zon/Mw, 2007, p 122; HM Buiting et al, 'Dutch experience of monitoring active ending of life for newborns', *Journal of Medical Ethics* 36, 2010, p 234, table 1.
89 Onwuteaka-Philipsen et al, *Evaluatie*, p 108.
90 Ibid, 108–9.
91 Often used as shorthand for the requirement that the suffering have 'no prospect of improvement'.
92 Onwuteaka-Philipsen et al, *Evaluatie*, pp 108–9.
93 MC Jansen-van der Weide, BD Onwuteaka-Philipsen and G van der Wal, 'Granted, undecided, withdrawn, and refused requests for euthanasia and physician-assisted suicide', *Archives of Internal Medicine* 165, 2005, p 1698, table 4 (95 per cent confidence interval (CI) = 6.9-33).
94 Ibid, table 4 (95 per cent CI = 3.3-39).
95 Ibid, table 4 (95 per cent CI = 2.1-9.1).
96 ME Van Dijk and C Van Wijlick, 'Zorgvuldige euthanasie', *Medisch Contact* 65, 2010, pp 1612, 1615, citing Regional Euthanasia Review Committees, *Jaarverslag 2007*, casus 5; Regional Euthanasia Review Committees, *Jaarverslag 2009*, casus 13 respectively.
97 SCEN, *Spiegelinformatie SCEN 2009*, 2011, table 4.5 (69.6 per cent in 2006, 68.8 per cent in 2008, 66.7 per cent in 2009; data from the most recently performed consultation).
98 Ibid, table 4.5 (10.7 per cent in 2006, 14.0 per cent in 2008, 9.5 per cent in 2009; data from the most recently performed consultation).
99 Ibid, table 4.5 (27.7 per cent in 2006, 21.5 per cent in 2008, 10.7 per cent in 2009; data from the most recently performed consultation).
100 BD Onwuteaka-Philipsen et al, 'The last phase of life: who requests and who receives euthanasia or physician-assisted suicide?', *Medical Care* 48, 2010, p 596, table 4.
101 Jansen-van der Weide et al, 'Granted, undecided, withdrawn, and refused requests for euthanasia and physician-assisted suicide'; I Haverkate et al, 'Refused and granted requests for euthanasia and assisted suicide in the Netherlands: interview study with structured questionnaire', *British Medical Journal* 321, 2000, p 865; JH Groenewoud et al, 'Psychiatric consultation with regard to requests for euthanasia or physician-assisted suicide', *General Hospital Psychiatry* 26, 2004, p 323.
102 CD Ruijs et al, 'Depression and explicit requests for euthanasia in end-of-life cancer patients in primary care in the Netherlands: a longitudinal, prospective study', *Family Practice* 28, 2011, [p 396].
103 G van der Wal et al, 'Evaluation of the notification procedure for physician-assisted death in the Netherlands', *New England Journal of Medicine* 335, 1996, p 1706, table 2.
104 Van Dijk and Van Wijlick, 'Zorgvuldige euthanasie', p 1615.
105 J Griffiths, A Bood and H Weyers, *Euthanasia and Law in the Netherlands*, Amsterdam: Amsterdam University Press, 1998, p 101, n 31.
106 Onwuteaka-Philipsen et al, *Evaluatie*, p 108.
107 Ibid, pp 108–9.
108 Jansen-van der Weide et al, 'Granted, undecided, withdrawn, and refused requests for euthanasia and physician-assisted suicide', table 4 (95 per cent CI = 4.2-1096).
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110 Onwuteaka-Philipsen et al, 'The last phase of life', table 4.
111 Jansen-van der Weide et al, 'Granted, undecided, withdrawn, and refused requests for euthanasia and physician-assisted suicide'; Haverkate et al, 'Refused and granted requests for euthanasia and assisted suicide in the Netherlands'; Groenewoud et al, 'Psychiatric consultation with regard to requests for euthanasia or physician-assisted suicide'.
112 Ruijs et al, 'Depression and explicit requests for euthanasia in end-of-life cancer patients in primary care in the Netherlands', p 4.
113 KNMG, Standpunt Federatiebestuur KNMG inzake euthanasie, [5.1.1]; NVP, *Richtlijn omgaan met het verzoek om hulp bij zelfdoding door patiënten met een psychiatrische stoornis*, [p 5].
114 NVP, *Richtlijn omgaan met het verzoek om hulp bij zelfdoding door patiënten met een psychiatrische stoornis*, [p 5.2] (stating that the rate is only 3 per cent); Groenewoud et al, 'Psychiatric consultation with regard to requests for euthanasia or physician-assisted suicide', 325, table 1, 328 (estimating that the rate of psychiatric consultation is about 4 per cent of all requests for euthanasia and assisted suicide and reporting almost twice as many requests for psychiatric consultation from psychiatrists than from non-psychiatrists).
115 Onwuteaka-Philipsen et al, *Evaluatie*, p 108.
116 Ibid, pp 108–9.
117 Spiegelinformatie SCEN 2009, Tabel 4.5.
118 Van Dijk and Van Wijlick, 'Zorgvuldige euthanasie', p 1615.
119 Griffiths et al, *Euthanasia and Law in Europe*, p 169.

120 Two such cases appear in the most recent annual report: Regional Euthanasia Review Committees, *Jaarverslag 2009*, casi 2, 13. In case 2, the patient had developed aphasia which prevented a written request but the Regional Euthanasia Review Committees was satisfied that the request by means of hand gestures, repeated at a later date in the presence of the patient's daughter, had been competent, and that the physician had paid particular attention to the issue of the patient's competence. In case 13, the patient had made repeated oral requests, but at the time of admission to hospital was no longer able to make a written request. Although this fact alone would not necessarily have resulted in a judgement of 'not careful', the fact that the consulted physician had not been able to assess the patient's capacity did result in such a judgement. For euthanasia to be provided to an incompetent patient, a written advance request is required.
121 Regional Euthanasia Review Committees, *Jaarverslag 2005*, casus 3.
122 Van Dijk and Van Wijlick, 'Zorgvuldige euthanasie', p 1615.
123 Regional Euthanasia Review Committees, *Jaarverslag 2007*, casi 11, 12; Regional Euthanasia Review Committees, *Jaarverslag 2008*, casi 5, 8, 9, 10, 11, 14.
124 Regional Euthanasia Review Committees, *Jaarverslag 2008*, casus 7; Regional Euthanasia Review Committees, *Jaarverslag 2009*, casus 14.
125 Regional Euthanasia Review Committees, *Jaarverslag 2008*, casus 6.
126 Spiegelinformatie SCEN 2009, table 2.4 (21.9 per cent in 2006, 19.4 in 2008, 24.9 per cent in 2009).
127 Van Wesemael et al, 'Consulting a trained physician when considering a request for euthanasia', table 4. The response rate among SCEN consultants and attending physicians was 100 per cent.
128 Ibid.
129 Ibid, table 2.
130 Ibid.
131 Ibid.
132 Ibid.
133 Ibid, p 508.
134 Spiegelinformatie SCEN, 2009, table 4.8.
135 Van Wesemael et al, 'Consulting a trained physician when considering a request for euthanasia', table 3.
136 MC Jansen-van der Weide, BD Onwuteaka-Philipsen and G van der Wal, 'Quality of consultation and the project "Support and Consultation on Euthanasia in the Netherlands" (SCEN)', *Health Policy* 80, 2007, pp 97, 104.
137 van der Wal et al, 'Evaluation of the notification procedure for physician-assisted death in the Netherlands', table 2; BD Onwuteaka-Philipsen, G van der Wal and L Wigersma, 'Consultation and discussion with other physicians in cases of requests for euthanasia and assisted suicide refused by family physicians', *Cambridge Quarterly of Healthcare Ethics* 9, 2000, p 381, table 1.
138 One nurse has been prosecuted for administering a euthanaticum to a patient under a physician's supervision. Griffiths et al, *Euthanasia and Law in the Netherlands*, pp 108–9.
139 GG van Bruchem-van de Scheur et al, 'The role of nurses in euthanasia and physician-assisted suicide in The Netherlands', *Journal of Medical Ethics* 34, 2008, p 254, table 5.
140 GG van Bruchem-van de Scheu et al, 'Euthanasia and assisted suicide in Dutch hospitals: the role of nurses', *Journal of Clinical Nursing* 17, 2008, pp 1618, 1622.
141 Ibid
142 Regional Euthanasia Review Committees, *Jaarverslag 2005*, casus 9.
143 Onwuteaka-Philipsen et al, *Evaluatie*, p 99.
144 Van Dijk and Van Wijlick, 'Zorgvuldige euthanasie', p 1615.
145 Regional Euthanasia Review Committees, *Jaarverslag 2008*, casi 12, 13, 14; Regional Euthanasia Review Committees, *Jaarverslag 2009*, casi 15, 16. Some of these cases have been defended on medical grounds by some of the physicians involved. See Sprij, 'Mag het ietsje minder zijn?'; Van Dijk and Van Wijlick, 'Zorgvuldige euthanasie', p 1613.
146 KNMP, Toepassing en bereiding van euthanatica.
147 Regional Euthanasia Review Committees, *Jaarverslag 2009*, casus 12.
148 Ibid, casus 18 casus 18. In this case, the patient put off his euthanasia appointment after the physician had arrived at his house. Unwisely, the physician left the euthanatica with the patient, who had promised to call him when he wanted to proceed with the euthanasia, and not to go ahead without the physician present. The patient took the euthanaticum and died without contacting the physician.
149 Ibid, casus 19 (the patient was too weak to do this by himself).
150 Ibid, casus 17.
151 van der Wal et al, 'Evaluation of the notification procedure for physician-assisted death in the Netherlands', table 2.

152 van der Heide et al, 'End-of-life practices in the Netherlands under the Euthanasia Act', table 1; Griffiths et al, *Euthanasia and Law in Europe*, p 198; Regional Euthanasia Review Committees, *Jaarverslag 2007*, *Jaarverslag 2008*, *Jaarverslag 2009*.
153 Onwuteaka-Philipsen et al, *Evaluatie*, p 15.
154 Ibid ; HM Buiting et al, 'Physicians' labelling of end-of-life practices: a hypothetical case study', *Journal of Medical Ethics* 36, 2010, p 24.
155 Onwuteaka-Philipsen et al, *Evaluatie*, p 15; ML Rurup et al, 'The reporting rate of euthanasia and physician-assisted suicide: a study of the trends', *Medical Care* 46, 2008, pp 1198, 1201.
156 Onwuteaka-Philipsen et al, *Evaluatie*, p 176.
157 L Van den Block et al, 'Nationwide monitoring of end-of-life care via the Sentinel Network of General Practitioners in Belgium: the research protocol of the SENTI-MELC study', *BMC Palliative Care* 6, 2007, p 6.
158 L Van den Block et al, *Het sterfbed in België: Resultaten van de SENTI-MELC studie 2005–2006 [The Deathbed in Belgium: Results of the Senti-Melc Study 2005-6]*, Brussels: Academic Scientific Publishers, 2007, p 89; L Van den Block et al, 'Euthanasia and other end-of-life decisions: a mortality follow-back study in Belgium', *BMC Public Health* 9, 2009, p 79, table 2.
159 L Deliens et al, 'End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey', *Lancet* 356, 2000, p 1806, table 1
160 van der Heide et al, 'End-of-life decision-making in six European countries', table 2.
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162 K Chambaere et al, 'Trends in medical end-of-life decision making in Flanders, Belgium 1998-2001-2007', *Medical Decision Making* 31, 2011, pp 500–10.
163 T Smets et al, 'Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases', *British Medical Journal* 341, 2010, p c5174, table 1. See also, K Chambaere et al, 'Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey', *Canadian Medical Association Journal* 182, 2010, pp 895–6; J Bilsen et al, 'Medical end-of-life practices under the euthanasia law in Belgium', *New England Journal of Medicine* 361, 2009, pp 1119–20.
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168 Ibid, p 188.
169 Ibid, p 190.
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182 Ibid, p e166.
183 Smets et al, 'Reporting of euthanasia in medical practice in Flanders, Belgium', table 3. Note that the response rate in this study was only 58 per cent so the data should be used cautiously.
184 Smets et al, 'Legal euthanasia in Belgium', table 3.
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201 Ibid, table 4. The response rate among SCEN consultants and attending physicians was 100 per cent.
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225 CFCE, *Brochure d'information déstinée aux médicins*, p 14. See also the following section on reporting.
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233 See ODHS, *Thirteenth Annual Report on Oregon's Death with Dignity Act*, p 1, for the most recent data at the time of writing.
234 Oregon Department of Human Resources, *Oregon's Death with Dignity Act: The first year's experience*, 1999, p 9; MP Battin et al, 'Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in 'vulnerable' groups', *Journal of Medical Ethics* 33, 2007, pp 591, 595.
235 ORS 127.800-127.995, 127.865 §3.11(1)(b). A sample form may be found at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/pharform.pdf (accessed 10 Jun 2011).
236 ODHS, 'Characteristics and end-of-life care of 525 DWDA patients who died after ingesting a lethal dose of medication as of January 7, 2011, by year, Oregon, 1998-2010', 2011, p 1 http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/yr13-tbl-1.pdf (accessed 7 Jun 2011). Other illnesses included alcoholic hepatic failure, corticobasal degeneration, diabetes with renal complications, hepatitis C, organ-limited amyloidosis, scleroderma, Shy-Drager syndrome, multiple sclerosis, meningioma, pulmonary disease, chronic heart failure, diseases of the heart, cerebrovascular disease, Parkinson's disease and Huntington's disease.
237 ORS 127.800-127.995, 127.800 §1.01(12) defines terminal illness as 'an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months'.
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251 See ODHR, *Oregon's Death with Dignity Act: The first year's experience*; ODHS, *Oregon's Death with Dignity Act: The second year's experience*; ODHS, *Oregon's Death with Dignity Act: Three years of*

*legalized physician-assisted suicide*, and the fourth to thirteenth annual reports on the Oregon's Death with Dignity Act.
252 ORS 127.800-127.995, 127.825 §3.03.
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260 Ibid, p 32: providing information about physician assisted suicide, 'including the law and the process required of patients, and permits its staff to engage in conversation… [D]irects patients to contact their attending physician or provides information about a patient education organization to help them identify an attending physician for the purposes of [physician assisted suicide], in addition to providing other patient services such as counseling or witnessing documents. Th[e] hospice… prohibits aid in securing or administering medications. However, it allows staff to be present with the patient and family members at the time the medication is ingested as part of its philosophy of being a "companion" on the patient's "journey".'
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